TOT 2 5 2013

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| OLIVILIY. | O LOIS MILDICARE & | MEDICAID SERVICES | | | MB NO. 0938-0391 |
|---------------|--|---|---------------------------|--|--|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | X3) DATE SURVEY COMPLETED |
| | | 345143 | B. WING | | 10/07/2013 |
| NAME OF PE | ROVIDER OR SUPPLIER | | ST | FREET ADDRESS, CITY, STATE, ZIP CODE | 10/07/2013 |
| | | | | 00 W DOLPHIN ST | |
| SILER CIT | Y CARE AND REHABIL | TATION CENTER | s | ILER CITY, NC 27344 | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | 1D | PROVIDER'S PLAN OF CORRECTION | 2/5 |
| PREFIX TAG | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | |
| F 000 | INITIAL COMMENTS | 3 | F 000 | Preparation and/or execution of this Plan of Co | rrection |
| | | | | does not constitute admission or agreement of | |
| | On 9/27/2013, the fa | sollity submitted on | 4 | provider of the truth of the facts alleged or con | |
| | | allegation for the removal of | | set forth in the statement of deficiencies. The F | and the second s |
| ļ | | rdy for the deficiency cited on | | Correction is prepared and/or executed solely I | |
| | | a of Notification of physician | | it is required by the provisions of federal and st | · · |
| | | of care and services (F309). | | 1. Resident #188 was admitted 10/3/12 w | |
| | | hat immediate jeopardy for | | diagnosis of end stage renal disease rec | |
| | residents was remov | • • • • | • | hemodialysis three times a week, gene | |
| | | | | weakness requiring physical therapy an | |
| | The Division of Heal | th Service Regulation | 1 | occupational therapy, Cornelia deLange | |
| | | p visit on 10/7/2013 to | | syndrome, Gout, hypertension, dyslipic | |
| | determine if the facil | ity had removed the | | asthma, hypothyroidism, obstructive sl | |
| | immediate jeopardy | identified during the survey of | | apnea, and obesity. Resident #188 was | |
| | 9/20/2013. | | • | at 2:30 a.m. on 2/7/13 as being nonver | |
| | | | | and fluttering eyelids. Nursing assistar reported this to the nurse. Nurse asse | |
| | ~ | at immediate jeopardy was | | resident as being lethargic, both eyes r | |
| | | a Notification of physician | : | and matted with yellowish green matter | |
| | | of care and services (F 309) | į. | cheeks flushed and warm, temperature | |
| | | facility remains out of | : | and noted to be 100.6, blood pressure | |
| | | level (No Actual Harm with | i | 100/60, pulse 66, respiration 20, reside | |
| | | nan Minimal Harm that is not | | thrashing both arm s and moaning dur | |
| | | /), to implement monitoring | | examination, oxygen saturation 84%, r | |
| (5, 4.5.2) | | ete employee education. | , | cannula reannlied, oxygen stats increa | 1 |
| | 483.10(b)(11) NOTI | | {F 157} | 98%. Nurse checked finger stick blood | |
| \$S=D | (INJURY/DECLINE/ | ROOM, ETC) | 4 | and read high. At 3:30 a.m. temperate | ure |
| | A facility must imme | diately inform the resident; | | recheck 99.1, no nausea or vomiting. | On 1 |
| | | ident's physician; and if | | 2/7/13 at 9:45 a.m. vital signs were | i e |
| | | sident's legal representative | + | temperature 98.6, pulse 60, respiratio | on 18, |
| | | nily member when there is an | | blood pressure 90/52, oxygen saturati | ion 84%, |
| | 1 | ne resident which results in | | resident noted to be unresponsive, sk | |
| | | otential for requiring physician | | to touch, moans with movement, lung | |
| | | ficant change in the resident's | | clear, finger stick blood sugar reading | |
| 1 | _ | psychosocial status (i.e., a | 1 2 2 | Nurse Practitioner notified of resident | t's |
| | The state of the s | Ith, mental, or psychosocial | • | condition at 10:30 a.m., give order to | |
| 1 | | hreatening conditions or | 1 | transport to hospital for evaluation. | |
| | | ns); a need to alter treatment | 1 | responsible party was call at 9:45 a.m | |
| | significantly (i.e., a | need to discontinue an | - | 2:45 p.m. but license nurse unable to | contact |
| <u> </u> | <u> </u> | | ì | as no one answered the phone. | <u>:</u> |
| LABORATOR | Y DIRECTOR'S OR PROVIDE | R/SUPPLIER REPRESENTATIVE'S SIGNATU | JRE . | TITLE | (X6) DATE |

Any definency statement ending with an asterick (') 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: 4DS512

Facility ID: 923120

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO. | 0938-0391 |
|--------------------------|--|--|----------------------|------|--|--|----------------------------|
| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | ING | DNSTRUCTION | (X3) DATE S COMPLI | |
| | | 345143 | B. WNG | | | 400 | 7/2042 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STRI | EET ADDRESS, CITY, STATE, ZIP CODE | 1 10/0 | 7/2013 |
| SILER CIT | Y CARE AND REHABIL | ITATION CENTER | | 900 | W DOLPHIN ST ER CITY, NC 27344 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | ₿E | (X5) COMPLETION DATE |
| {F 157} | existing form of trea consequences, or to treatment); or a decident resident from the §483.12(a). The facility must also and, if known, the resident room or respecified in §483.1 resident rights under regulations as specified in §483.1 resident r | tment due to adverse o commence a new form of ision to transfer or discharge e facility as specified in o promptly notify the resident esident's legal representative member when there is a commate assignment as 5(e)(2); or a change in a Federal or State law or iffed in paragraph (b)(1) of cord and periodically update one number of the resident's e or interested family member. NT is not met as evidenced sition, record review, physician, estaff and Emergency Medical erviews, the facility failed to the physician of a significant at 188, reviewed for ges. Ity began on 2/7/13 when e aware of Resident #188's in including: lethargy, periodic II, and elevated blood sugar, the physician. The Immediate | {F | 157} | Residents residing in the Facility had medical records reviewed for any che condition to ensure that the physicia been notified. This review was done 9/20/13 by Assistant Director of Nut 1st Shift Registered Nurse Supervisor Registered Nurse Reimbursement Coordinator. During the review on sonly one resident was noted to have of condition, complained of pain. Rephysician was notified on 9/20/13 by Assistant Director of Nurses, obtain order for x-ray and lab work. 38 of 38 licensed nurses were re-ed Nursing Administration by 9/21/13 guidelines for physician notification telephone and after office hours phe call to notify by telephone. The edu included notifying physician of about pain that is severe or lasting more hour, any new pain or self-limited vomiting, change in blood pressure than 210/120 or less than 80/50 or patient baseline, blood sugars great 400or less than 70 or per physician parameters, any new chest pain we shortness of breath, nausea or dia diarrhea more than four times in the if occurring with associated frank in new onset with swallowing or spenew onset, or not responsive to puredication, pulse greater than 12 50 or change from baseline of residential more than once in 24 hobright red blood is present, new or bright red blood i | ange of an had e on rses, the r and the 9/20/13 e a change esident's by ed an ucated by on by ysician on cation dominal than one by e greater r per ater than n's with phoresis, two hours or blood, any aking, pain rescribed O less than ident, as than 8 and of breath, urs or if any | 9/20/13 |
| | | cility's credible allegation was /13. Residents on all halls | : : : | : | weakness of arm or leg. Any licen who were unavailable for re-educ not be allowed to work until the e | ation will | 9/21/13 |

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| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NC | 0. 0938-0391 |
|--------------------------|---------------------------------|---|----------------------|------|--|---------|----------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A BUILDI | | NSTRUCTION | | LETED |
| | | 0.154.0 | D WING | | | _ | -C |
| | | 345143 | B. WING | | | 10/ | 07/2013 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | EET ADDRESS, CITY, STATE, ZIP CODE | | 1 |
| SILER CI | TY CARE AND REHABI | LITATION CENTER | | 4 | W DOLPHIN ST | | |
| | | | | SILE | ER CITY, NC 27344 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | 1 | | • | | 38 of 38 licensed nurses were re-educate | ed by | |
| {F 157} | Continued From pa | ge 2 | {F | 157} | 9/21/13 by Nursing Administration on sc | | |
| | | , and 500) in the facility | • | | problems when using the glucose monit | | |
| | | ved and observations were | | | system including the codes that may app | oear: | |
| 1 | | ents who had changes in | | | "H!" indicates that the blood glucose rea | | |
| | conditions. The obs | = | | | is above 600 mg/dl and "Lo" blood gluce | ose | |
| 1 | | iated with change in | | | reading is below 20 mg/dl. Education in | cluded | . |
| | | porting/communication | | : | that when these codes appear they sho | uld |] |
| | | o shift, staff documentation of | | 1 | wash and dry hands of the resident and | | |
| | observed changes | in condition in accordance with | | | repeat the test with a new test strip. If i | | |
| | the facility newly de | eveloped guidelines/tools | | | still are "Hi" or "Lo" contact physician. | The | j |
| İ | (9/21/13). The SBA | R (Situation, Background, | | | Facility uses only one brand of glucome | | |
| | Assessment and | | | | the future, if the brand of glucometer is | š | |
| 1 | | Request)/Change in Condition | | | changed, licensed nurses will be educat | ed on | |
| l | | for all residents from 9/21/13 | | | usage from the manual that is provided | | 1 |
| | -10/7/13 were revie | ewed. | į | | the glucometer. The manual for the cur | rently | 1 |
| | | | | | used glucometer are located on each | 411 | |
| | | ere completed to verify the | į | | medication cart. Administrative Nurse | | : |
| | • | the assessment tools and the | : | | complete competencies on licensed nu | rses | |
| | • | of staff communication | | | when to notify physician on condition | change, | |
| | | change of condition use of the | i | : | assessing change of condition, the use | or the | ì |
| | | ol and glucometer training with | | ì | Interventions to Reduce Acute Care Tra | | |
| | all shifts of medica | i stait. | į | | (INTERACT) Tools and troubleshooting | | 1 |
| | : Ctoff intonious wa | ere conducted with all three | | ! | glucose readings. Starting 9/21/13 five | | |
| İ | | nplementation of the newly | ŀ | - | licensed nurses per week across all thr | | |
| | | Situation, Background, | 1 | | shifts will complete their competencie | | |
| | | ommendation/Request) form, | į | i | weekly for one month, then monthly f | OI CWO | |
| | | nange in Condition form , | : | ! | months. Licensed nurses will sign the education record at the time of compl | leting | |
| | | ig ,Early Warning " Stop and | | , | competencies and a copy of competen | | |
| | | SBAR form indicating review of | | ĺ | will be placed in the individual employ | vee | |
| | | nd knowledge of the resident | : | 1 | education file located in the Staff | | _ |
| | | on had been completed by | | ! | Development Coordinator's office. | | 9/21/13 |
| | | redible Allegation. Direct Care, | : | 1 | Development coordinator a cistos. | | , 11411/O |
| | | Staff interviews were | : | ; | | | į |
| | | y current staff and agency staff | <u>†</u> | i | | | |
| | had been in-service | ced in the new systemic | : | | | | ! |
| 1 | | ocols. The completion date for | | i | | | } |
| | | nursing and nursing assistant | | | | | |
| İ | , became effective | - | | | | | i |

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | OMB NO. 0938-0391 |
|--------------------------|---|---|-------------------------------|--|--|
| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CON A. BUILDING | STRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 345143 | B. WNG | | 10/07/2013 |
| | ROVIDER OR SUPPLIER Y CARE AND REHABILI | TATION CENTER | 800 W | T ADDRESS, CITY, STATE, ZIP CODE DOLPHIN ST R CITY, NC 27344 | 1 (8,6)/26(6 |
| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION |
| {F 157} | 9/22/13 through 10/6 all the supportive do Allegation of Compliminglementation of the of Compliance. The survey found the removed for the area physician of a signification of lethargy, periodic elevated blood sugar facility remains out of (No Actual Harm with Minimal Harm that is order to continue imand monitor system) Findings included: Resident #188 was 10/3/12. Her diagnod diabetes, anemia, eclostridium difficile, wasting, dialysis, and The quarterly Minimal participated in the assistance with activation on oxygen, and A review of the Febrevealed there were monitoring, oral or medications. Ther | ce Audit reports since i/13 were reviewed along with cumentation of the Credible ance, to verify the e facility's Credible Allegation at immediate jeopardy was a of notification of the cant of Condition as a result thrashing, moaning, and ir, (F157) on 9/21/13. The of compliance at the D level th Potential for More than is not Immediate Jeopardy), in plementation of the process s. admitted to the facility on uses included hypertension, and stage renal disease, muscle weakness, muscle and asthma. num Data Set (MDS) 1/4/13 indicated the resident ct, did not reject care, assessment, needed extensive livities of daily living (ADLs), | {F 157} | 50 of 57 Certified Nursing Assistants of educated on 9/21/13 on the INTERAC Warning Tool "Stop and Watch" that Nursing Assistants to circle the noted change and discuss with their charge nurse. Changes listed are Seems differ than usual, Talks or communicates le usual, Overall needs more help than a Participated in Activities less than usual change, Agitated or nervous more the Tired, weak, confused or drowsy, Chaskin color or condition and Help with transferring, tolleting more than usual Certified Nursing Assistants who are unavailable for re-education will not allowed to work until the education completed. Starting 9/22/13, Competite use of the Early Warning Tool will completed on 15 Certified Nursing A across the three shifts weekly for on then monthly for two months. Certification Nursing Assistants will sign the education across the time of completing competencies and a copy of the competencies will be placed in the interpolation of the competencies will be plac | asks the asks the aresident aresident aresident aresident aresident aresident aresident aresident are usual, ange in area are are are are are are are are ar |
| | | very 6 hours for pain. | | | |

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| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO | 0. 0938-0391 |
|--|--|--|----------------------|--|--|--|----------------------------|
| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | TIPLE CONS | (X3) DATE SURVEY COMPLETED | | |
| · | 70.50 | 0/2/0 | B 114110 | | | R | FC |
| | | 345143 | B. WING | , | | 10, | 07/2013 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | 1 | FADDRESS, CITY, STATE, ZIP CODE | | |
| SILER CIT | Y CARE AND REHABIL | ITATION CENTER | | | DOLPHINST | | |
| | | | | SILER | CITY, NC 27344 | *********** | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAC | ·ΙΧ | PROVIDER'S PLAN OF CORREC'TI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .DBE | (X5) COMPLETION DATE |
| {F 157} | indicated the resider degrees, was alert a | report and resident's documented change of the resident had a temperature of 100.3 daily for 30-days, there was alert and verbal, made her needs | | Nursing Administration will review report and resident's clinical record documented change of condition a documentation of notification of p daily for 30-days, then weekly for 6 monitoring tool was developed to | d for any nd hysician 50-days. A | : | |
| | | ted 2/6/13 at 10:30 am It was transported to dialysis | | : | completion of the audits of the 24 report, resident's clinical record ar documentation of notification of principles monitoring tool will be maintable Director of Nurses office. The Director of Nurses office. | -hour nd hysician. ained in the | |
| | Other than the Change o Documentation, there we notes written on Residen 10:30 am to 2/7/13 at 9:4 | e were no other nurse's sident #188 from 2/6/13 at | : | 1 | Nurses will present to the Perform Improvement Committee the resumentioring of medical records for notification, results of license nurse competencies for notification of p | lts of the ses | 9/21/13 |
| | completed by Nurse "At 2:30 am [Nurse and non-verbal and flutter resident lethargic, b | dition Documentation form, #1 and dated 2/7/13, stated, Aide #1] reported resident ering eye lids. Nurse noted oth eyes reddened [with] tter. Cheeks flushed [and] | | : | assessing change of condition of r and troubleshooting glucometer f | | Ongoing |
| | warm. Temp 100.6. arms during examin sound similar to a cout of nostrils [and cout of nostrils] | Periodically thrashing both ation [and] moaning [with] at 's meow. Nasal cannula bxygen saturation] 84%. | | ; | | | |
| | increased to] 98%. eyes, removing mat [orally]. Crushed [du | at] 4 L [with oxygen saturation Bipap replaced. Cleansed Iter. Gave Vicodin 5-500mg Le to] decreased [level of | · | | | 1 | ; |
| Andrew Control of the | quality of moaning (stimulus. Resident | necked blood sugar due to with] reading Hl. Decreased said 2-3 words but still not 45 am [temperature] 99.1. | : | | | | |
| | [No] nausea or vomiting. Continue to moan [and] throw arm slowly at times." Vitals signs were documented at 2:30 am as: blood pressure 100/60, pulse 56, temperature 100.6, respirations | | | ; ; ; | | | : |
| | 20, and blood suga | • | | 1 | | | |

| STATEMENT O AND PLAN OF | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | TIPLE CONS | TRUCTION | (X3) DATE SURVEY COMPLETED | |
|----------------------------|---|--|-----------------------|-------------|---|-------------------------------|----------------------|
| | | 345143 | B. WING | | AND THE RESIDENCE OF THE PARTY | R-C 10/07/201 | 3 |
| | ROVIDER OR SUPPLIER Y CARE AND REHABII | LITATION CENTER | . | 1 W 00e | ADDRESS, CITY, STATE, ZIP CODE DOLPHIN ST CITY, NC 27344 | 1 10/07/201 | <u>.</u> |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMP | K5) LETION ATE |
| {F 157} | Continued From pa | ge 5 | {F | 157} | | : | |
| | The Medication Administration Record (MAR) dated 2/7/13 indicated at 2:30 am Resident #188 was given Vicodin 5-500mg by mouth for pain. | | : | · | | | |
| | There was no docu medication was effe | mentation indicating if pain ective. | ! | ! | | | |
| | "Resident unrespondack in head, Moan by staff, Unable to | ted 2/7/13 at 9:45 am stated, asive. Opens eyes then roll as with movement of any kind verbalize anything. [Blood Refused breakfast this a.m. | 1 ; | | | | |
| | | dated 2/7/13 at 10:14 am mergency department] for sciousness." | | | e, met | | |
| | stated, "Nurse noti resident was non r - decreased [level | ated 2/7/13 at 10:15 am fied supervisor at 9:45 am that esponsive. Assessed [patient] of consciousness] noted. ive to light, sluggish." | | | | : | |
| | indicated Emerger was at the facility t | ated 2/7/13 at 10:30 am acy Medical Services (EMS) to transport the resident to the urse Practitioner was notified. | 1 | ; ; ; | | | |
| | report dated 2/7/13 nursing home, [Re | edical Service (EMS) transport 3 stated, "Per nursing staff at sident #188] began eased [level of consciousness] | | | | | |
| | last [night]. She is [non-insulin-deper dialysis yesterday | a dialysis [patient] and added added added and added added added and added added and added | | | | | |
| | [level of conscious [blood glucose lev | gan experiencing decreased sness) with fever. Per nurse her el] at that time was over 400. sident] is not responding. Lies | : | | | | |

| • | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | FIPLE CONS | TRUCTION | (X3) DATE SURV COMPLETE | |
|--------------------------|--|--|------------------------|--|---|----------------------------|---------------------------|
| | | 345143 | B. WING | | | R-C 10/07/2 | 013 |
| | ROVIDER OR SUPPLIER TY CARE AND REHABIL | ITATION CENTER | | 900 W E | ADDRESS, CITY, STATE, ZIP CODE DOLPHIN ST CITY, NC 27344 | | |
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| {F 157} | Continued From page | de 6 | {F | 1573 | | | |
| {F 157} | staff calls 911." The the report was "Unrome hours" and the diagonomess, Dia During a telephone Supervisor, on 9/22 "Duration" time on a amount of time the been occurring prior A review of the hos | I moans (no words). Nursing e chief complaint indicated on esponsive patient. Duration: 9 nosis was "Altered level of | {F | 157}: | | | |
| | admitted on 2/7/13 from cardiopulmons shock. The dischalance emergency departragitated, yelling no loose stools. She wand admitted to the She was partially revasopressor supports blood pressure), an obtained. Due to experience of the shock in the shock of the shock in the shock | and passed away on 2/11/13 ary arrest secondary to septic rge summary stated, "In [the ment] [patient] was found to be nsensically, and had multiple was subsequently intubated e medical [intensive care unit]. esuscitated, requiring ort (medication to maintain her and a surgical consultation was evidence of peritonitis e lining of the abdomen), an | | | | | |
| | exploratory laparot inside of the abdor which demonstrate resection was perf transferred to the same Aggressive attemp stabilization were compartment syncintra-abdominal probedside laparotom cavity) was performintra-abdominal promiterial properties of the abdominal properties of th | tomy (incision to examine the minal cavity) was performed, and bowel perforation. Bowel cormed and the patient was surgical intensive care unit. Outs at resuscitation and unsuccessful. Abdominal drome (elevated essure) was recognized and a pay (incision into the abdominal | | A COMMANDE AND A COMMAND AND A | | | |

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| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | | STRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|-----------------------|---|---|-------------------------------|
| | | 345143 | B. WiNG | | | 10/07/2013 |
| | ROVIDER OR SUPPLIER Y CARE AND REHABIL | ITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN ST SILER CITY, NC 27344 | | 10,01,20,70 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETIO |
| {F 157} | Continued From pag | ge 7 | {F | 157}i | | I |
| | During on interview | on 9/19/13 at 12:05 pm, | | | , | |
| | | | | | | |
| | | er blood sugar was low that | : | 1 | | |
| | - | s sent to the [emergency | - | | | • |
| | | report from [Nurse #1] that | | | | |
| | | rent and her blood sugars | | 1 | | |
| | • | rse #1) said she filled out a | | | | |
| | | form. When you fill out the | | • | | |
| | | ally notify the physician. The | | į | | · |
| | | ors that morning. She was | 1 | i | | |
| | • • | id oriented and would answer | | | | |
| | | tely. She took her medicine | | : | | |
| | | but didn't eat breakfast. | : | i | | |
| | | r after breakfast, she was not | ! | | | |
| | - | ch as before breakfast so I | | | | |
| | | sugar. She wouldn't respond | | | | |
| | | ne. I don't recall [Nurse #1] | 1 | | | 1 |
| | | er than she had filled out the | | : | | • |
| | change in condition | form." | | | | |
| | 1 | | | | | 1 |
| | , – | on 9/19/13 at 12:30 pm, the | | | | |
| | | stated, "Intermittant [blood | | | | |
| | | would be documented in the | | ţ | | i i |
| | 1 | use it would not be on the | | | | |
| | | said 'HI', I would expect the | | ; | | |
| | • | echecked. If it remained 'HI', I | | ļ | | |
| | | hysician to be contacted, | | ; | | |
| | | esident's condition and level of | : | ; | | |
| | | change for that particular | : | 1 | | |
| | | ame in the nurse told me | | į | | : |
| | _ | n mental status and that the | | 1 | | ! |
| | 1 | was called and EMS was | ! | l | | 1 |
| | 1 | indicated that had she known | i | | | |
| | | ndition, including change in | i | i | | |
| | T . | ted blood sugar, at 2:30 am | 1 | į | | : |
| | | lled EMS. She further | ! | | | |
| | | ge in behavior and low blood | : | | | : |
| | , - | in transport to the hospital on | | ı | | |
| | 77773 at 10'30am' | would have been the same | • | 1 | | |

| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|--------------------|---------------------------------------|---|-------------------------------|--|
| | | 345143 | B. WNG | | | R-C10/07/2013 | |
| | ROVIDER OR SUPPLIER Y CARE AND REHABIL | ITATION CENTER | | 900 W | FADDRESS, CITY, STATE, ZIP CODE DOLPHIN ST CITY, NC 27344 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LEC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION | |
| | | | * | 1 | | | |
| {F 157} | Continued From pag | ge 8 | {F 1 | 157}: | | • | |
| | | the resident on 2/7/13 at 2:30 documented change in | | | | | |
| | beliavior and mgm b | iood adgai. | , | i | | | |
| | During an interview | with the Assistant Director of | | ÷ | | | |
| | | 9/19/13 at 11:39 am, she | : | | | | |
| | | an elevated blood sugar, | ! | | | | |
| | there would be a do | ctor's note stating to give | | | | | |
| | | was in distress and a blood | | i | | | |
| | sugar was checked | , it would be documented in | | | | | |
| | | see a blood sugar of 57 on | | | | | |
| | | any documentation of an | | | | | |
| | _ | ar." "The night nurse would | | 4 | | | |
| | | nge in condition to the | | | | | |
| | | keep the face sheets as part | | | | | |
| | | re is no way to know what | | ; | | | |
| | | was notified by fax. There is | i | | | | |
| 1 | | d expect the physician would | , | : | | • | |
| | | not just a fax sent, since it was when the change occurred." | : | i | | į | |
| | 2.50 in the monthly | when the change occurred. | i | į | | · | |
| | During a telephone | interview with Nurse #1 on | | | | , | |
| | | n, she stated, "I think | : | • | | ' | |
| | | pehavior led me to check her | : | | | | |
| | | wasn't really talking. This was | | <u> </u> | | | |
| | | he usually spoke in full | | ; | | I. | |
| | | s easy to understand. I took | 1 | | | • | |
| | her blood sugar as | a vital sign. 'HI' would mean it | ; | į | • | | |
| 1 | | e was not diagnosed with | | : | | | |
| | • | hecked because she was | ļ | j | | | |
| | , - | abetics with high sugar. She | : | | | | |
| | | nal about an hour later and | | i | | † | |
| 1 | | ontact so I faxed the doctor the | ŧ | | | ! | |
| | | n form. I did not call because | | 1 | | • | |
| | | better. I did not get an order | 1 | ì | | • | |
| | | any insulin or other medication | į. | į | | 1 | |
| | | blood sugar. If her behavior I would have called the doctor. | : | 1 | | | |
| 1 | | riting a note about her | | | | 1 | |

| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | | STRUCTION . | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|--|--------------------|-------|---|-------------------------------|
| | | 345143 | B. WNG_ | | | R-C 10/07/2013 |
| | NAME OF PROVIDER OR SUPPLIER SILER CITY CARE AND REHABILITATION CENTER | | | 900 W | TADDRESS, CITY, STATE, ZIP CODE DOLPHIN ST CCITY, NC 27344 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLE |
| JE 157) | Continued From pa | one 0 | íc í | 1571 | | |
| 11 10/ | | | {F | 157}! | | |
| | | g. I did not recheck her blood | | : | | |
| | - | e did not have an order for | | | | |
| | | nitoring) or a diabetes | i | | | |
| | diagnosis." | | | i | | |
| | During a talanhan | intopiow with the Nurse | 1 | | | |
| | | e interview with the Nurse 9/13 at 3:39 pm, she indicated | | | | |
| | | office, and not in the facility, | | . ; | • | |
| | | diately receive an incoming fax | | | | |
| | - | "If there is a change in a | | | | |
| | - | ney should call the on-call | | i | | |
| | | always someone on call. That | 1 | | | |
| | • | especially if the resident is | | | | |
| | | Even if they can't contact a | | | | |
| | | uld go ahead and call EMS with | | | | |
| | | r and the resident being | | | | |
| | • • | e expectation is the same if the | | | | |
| | | and they are symptomatic. | | | | |
| | - | he physician and call EMS. | | ! | · | <u>:</u> |
| 4 | | vait on a response from a fax | | | | |
| | | get seen right away. I | | : | | |
| | | y I was called and told she was | | | | 1 |
| | sent out and I did | not receive the faxed change in | | | | |
| | condition until after | er she had already left the | ; | | | |
| | facility." | | F | | | |
| | : During a telephon | e interview with the Physician | • | | | • |
| | | 1 pm, he stated, "If there is a | , | į | | |
| | | ent's condition, the facility | | | | . 1 |
| | | ly contact EMS and contact the | Į. | | | |
| | | My group policy is a 10-15 | ŀ | 1 | | |
| | | They should never wait. If the | | i | | ! |
| | | a change in condition form, | • | 1 | | |
| | | illing the physician. They have | | 1 | | , |
| | | ct, secondary contact, and even | | | | |
| | | can always be contacted." The | í | į | | |
| | | ed, regarding Resident #188, the | | ţ | | |
| 1 | | e called the physician at 2:30 | i | | | |
| | am when the cha | nge in condition was recognized. | | 1 | | i |

| CENTIFIC | JI ON MEDIONINE W | MEDICKID SEKVICES | | | OMD 140. 0830-0381 |
|--------------------------|---|--|---------------------------------|---|---|
| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING | | (X3) DATE SURVEY COMPLETED |
| | | 345143 | B. WNG | | R-C 10/07/2013 |
| NAME OF DE | ROVIDER OR SUPPLIER | 1 | | ET ADDRESS, CITY, STATE, ZIP CODE | 1 10/07/2013 |
| | | | Į. | V DOLPHIN ST | |
| SILER CIT | Y CARE AND REHABILI | TATION CENTER | SILE | R CITY, NC 27344 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | HOULD BE COMPLÉTION |
| , | | | | | |
| {F 157} | Continued From pag | e 10 | {F 157} | | |
| | 9/20/13 at 1:25 pm, I a change of condition protocol and procedu | with the Administrator on ne stated, "I would expect in n for the nurse to follow ure and follow her nursing ontact the physician and or | | | |
| (F 253) SS=E | pm of the Immediate Jeopardy is present | EKEEPING & | {F 253} | Amended Plan | of Correction |
| | maintenance service | vide housekeeping and es necessary to maintain a d comfortable interior. | , 1 , | The Maintenance Director ordere and the exposed pipes in the mai shower room between 100 and 4 removed and a door lock was inst Maintenance staff on 10/8/13. | in community 100 halls were |
| | by: Based on observation resident interviews to maintenance service safe, orderly, and control to the safe. | ons, record reviews, staff and the facility failed to provide es necessary to maintain a comfortable interior on 5 of 5 200, 300, 400 & 500). | | The Maintenance staff repaired a hall shower room sink on 9/27/1: The Maintenance staff repaired to Room 413 on 9/27/13. The Maintenance Director orders | 3. the door knob for |
| | The findings include | d: | | material to correct the Room 206 9/23/13. The sheetrock work was ceiling panel was scheduled to be | s completed and the |
| | to 4:00 PM the follor on five resident hall. The main communit resident halls 100 a unlocked and unuse covered in the main In the 500 hall show | y shower room between nd 400 was observed ed with pipes exposed and not | | The Maintenance Director ordered materials to correct the Room 20 9/23/13 and the sheetrock in Rocscheduled to be repaired, as ordedelivered, by the Maintenance st | /8/13. ed the appropriate 09 deficiency on om 209 was ered materials were |

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | OWR NO. 0838-038 |
|--|--|---|---------------------|--|-------------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| tere american est en en en en en en en en en en en en en | | 345143 | B. WING | | R-C 10/07/2013 |
| NAME OF PR | ROVIDER OR SUPPLIER | | STF | REET ADDRESS, CITY, STATE, ZIP CODE | |
| | | | 900 | W DOLPHIN ST | |
| SILER CIT | Y CARE AND REHABIL | TATION CENTER | i i | ER CITY, NC 27344 | |
| | OUR HARVE | TATELLE OF DESIGNATION | | | ONE OFF |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | IATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE COMPLETION |
| (E.050) | , | | ! | - District Programme and Ample | rialan |
| {F 253} | Continued From pag | | {F 253} | The Maintenance Director ordered mate | |
| | | had a one inch movement. | | 9/24/13 and the floor molding in Room | |
| | | to residents' room 413 was | 1 | repaired, by the Maintenance staff on 10 |)/4/13. |
| | not secure exposing | | | The Maintenance Director ordered the a | ennronriate |
| | | d in the walls. In residents' | | materials on 9/24/13 and the bathroom | |
| | | a hole through the sheetrock | 1 | Room 311 was repaired by the Maintena | |
| | | and the ceiling panel was | | 10/1/13 | |
| | | holes in sheetrock in the | 1 | 10/1/13 | |
| | | 3 holes in the sheet rock in | | The Maintenance Director ordered the a | appropriate |
| | | eye level. In room 404 the | i | materials on 9/23/13 and the sheetrock | |
| | providing a hole. | ulling away from the wall | ' | and 511 was scheduled to be repaired, a | |
| | , • | 311 bathroom was observed | | ordered materials were delivered, by th | |
| | · · | ken tile around the toilet and | į | Maintenance staff by 10/8/13. | |
| | • | ransition between room and | | | |
| | bathroom. | farished between room and | | The television cables in Room 103 and 2 | |
| | In residents' room 2 | 03 there were gouges in the | | removed on 9/28/13 by the Maintenan | ce staff. |
| | in the wall at both he | room 511 there were gouges | | The Maintenance Director ordered the | appropriate |
| | | re observed. In residents' | | parts on 9/23/13 for the folding closet of | doors. The |
| | | on cable was observed | | folding closet doors in Room 201, 207, | |
| | 1 | for a length of approximately 2 | İ | 307, 314, 315, 316, 404 were scheduled | d to be |
| | | ge exposed. In room 209 a | İ | repaired, as ordered parts were deliver | ed, by the |
| | television cable was | s observed hanging out of wall | • | Maintenance staff on 10/8/13 | |
| | and not in use. | oximately ten feet knotted up | 1 | The folding closet door knobs in Room | |
| | | 201, 207, 211, 212, 306, 307, | İ | 316, 406, 410, and 415 were repaired b | |
| | | 104 was observed with the | ļ į | Maintenance staff on 9/25/13. | ı |
| | | off track and freely swinging. | 1 | 1 | |
| | | 109, 202, 206, 316, 406, 410, | | The Maintenance Director ordered the | |
| | The state of the s | closet door knob was missing | | materials on 9/23/13 and the in-progre | |
| | or loose and dangling | | | repairs in Room 206, 412, 506 and 507 | were |
| | | II patches that were not | | continued and scheduled to be complete | ted, as the |
| | | vere found in residents ' | 1 | ordered materials were delivered, by the | he |
| | , - | 507. And in residents' room | | Maintenance staff. Completed 10/8/13 | - |
| | | oserved patched with the | | | : |
| | un-matching paint. | • | İ | The shower room across from the 400 | hall nurse |
| | | ird shower room being used | | station was re-labeled as a storage root | m by the |
| | | from the 400 hall nurse station. | | Maintenance Director. Completed 9/24 | 1/13 |
| | The room was locke | ed labeled shower room. | 1 | | |

PRINTED: 10/09/2013 FORM APPROVED OMB NO. 0938-0391

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO. 0938-0391 |
|---|--|---|-------------------|------|--|--------------------------------------|
| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | NG | STRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 345143 | B. WNG | | The second of th | R-C |
| NAME OF DE | ROVIDER OR SUPPLIER | | | | ET ADDRESS, CITY, STATE, ZIP CODE | 10/07/2013 |
| MANIE OF FE | NOVIDER ON OUT FILE | | | | DOLPHIN ST | |
| SILER CITY CARE AND REHABILITATION CENTER | | | | | R CITY, NC 27344 | |
| | OLE STATE OF THE S | TATELLE DE DECIDIONE | | | | TOOL |
| (X4) ID PREFIX TAG | (EACH DEFICIENT | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE COMPLETION |
| (F.050) | | . 40 | | .=0. | | |
| {F 253} | Continued From pag | | (⊢ 2 | 253} | | |
| | | facility was conducted on | | 2. | The Maintenance Director, Mainten | ance Assistant, . |
| | a contract of the contract of | 0 AM to 11:00 AM. The same | | ۷. | Housekeeping Supervisor and Admir | |
| | | nade on resident halls 100, | | | conducted a tour of all facility reside | |
| | | 00 excluding room 507. The | | | shower rooms, dining rooms and ac | |
| | | the walls in resident room | | | identified any facility environmenta | repair needs. |
| | 507 had been sande | ed and painted. | | | Completed 9/23/13 | • |
| | | AM the Director of Nursing | ; | 1 | The facility's Maintenance Work Or | fer process was |
| | • | staff filled out a maintenance | 1 | 3. | re-organized by the Administrator a | nd Maintenance |
| | | rbally told maintenance about | | | Director. There are now four distinct | t locations within |
| | | intenance was on call for an | | | the facility, the main Nurses Station | |
| ! | | a water leak or a broken | i | | kitchen and the 500 hall where Wo | |
| | | ne small things could wait till | į | | may be obtained and placed when | |
| | | proken wheelchair. The DON | ! | | facility's Maintenance staff will che | |
| | = | new how to fix the call lights. | | | Order locations at least twice daily | |
| | | ation of her staff to notify her, ell maintenance for facility | | | facility's Nurse Supervisor will chec | |
| | | revealed her staff was focus | | | locations at least twice daily on we | |
| | • | and wheelchairs and | : | | the Maintenance staff of needed re | |
| | maintenance went | around and painted. She | 1 | | appropriate. Completed 9/20/13 a | nd Ongoing |
| | | ng what maintenance system | | | The facility Administrator will recei | ve a copy of each |
| | | airs. The DON's expectation to handle structural | Ì | | Work Order when initially reported | l and then a copy |
| | 1 | urses were focused on | l | | of the Work Order when the work | |
| | equipment failures. | uises were locused on | | | Administrator will monitor the pro | |
| | | w on 9/19/2013 at 3:51 with | Ì | | Work Order. Completed 09/23/20: | |
| | 1 | resided in room #209, | | | | |
| | | ed the holes in the bathroom | : | | All facility staff was in-serviced on | the facility's Work |
| | | or seven to eight months. | | | Order process including what and | when to complete |
| | | 54 PM Resident #99, who | : | | a Work Order and the locations fo | r the Work Orders. |
| | | 16, who was cognitively intact | 1 | | Completed 9/20/13 | |
| | : | door in the room had been off | : | | | - Housekaaning |
| | track and the knob | missing for weeks. | | | The facility's Maintenance Directo | |
| 1 | On 9/19/2013 at 3: | 57 PM Resident #136, who | | | Supervisor and Administrator will | conduct rounds |
| | | #410 and was cognitively | | | weekly of the facility, including all | |
| | 1 | closet door knobs in the room | į | | shower rooms, dining rooms and a Utilizing a facility auditing tool, en | utranmental issues |
| 1 | | over a year. The resident | İ | | will be identified and scheduled for | vironmentariosaes vr attentinn ac |
| 1 | explained the main | tenance staff tightened the | | 1 | will be identified and scheduled to | n attenuon as |

door knobs up but they are worn out.

appropriate. Completed 09/27/2013 and Ongoing.

| <u></u> | MEDICAID SERVICES | | | | OME NO. | 0930-0391 |
|--|--|------------------------|-------|--|---|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | | NSTRUCTION | (X3) DATE S COMPL | ETED |
| | 345143 | B. WING | | | 100 | |
| NAME OF PROVIDER OR SUPPLIER | | | STRE | ET ADDRESS, CITY, STATE, ZIP CODE | 10/0 | 07/2013 |
| SILER CITY CARE AND REHABILE | TATION CENTER | | 900 V | V DOLPHIN ST R CITY, NC 27344 | | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| resided in room 103 revealed the exposer room 103 had been lover a year. On 9/19/2013 at 4:06 resided in room 203 revealed he was trying environment and the in the room prior to he reported one of the used for storage. He refrigerator but was system would not he And the handicap be courtyard had not be An interview with the 9/19/2013 at 10:40 work orders received not sooner. He reported and maintenance toilets and sinks. The walls from beds maintenance Superstuff as he walk down into the resident room verbally asking for salways write the stall A record review of the orders revealed required the wall at the head 9/17/2013 a wall ne in room 101; on 9/1 and on 9/10/2013 the and bathroom need | and was cognitively intact, dunused television cable in hanging out of the wall for and was cognitively intact, and was cognitively intact and to create a homelike facility did not patch the wall his last roommate's arrival, he shower rooms was being wanted to bring a told by the staff the electrical old the bed and a refrigerator. And revealed he completed a from staff with in 2 weeks if arted the facility was 44,000 sque was busy with clogged here were constant holes in and wheelchairs. The visor revealed he looked at and wheelchairs. The visor revealed he looked at and the halls but he did not go ms. The staff was always tuff to be fixed. He did not firequest down: The current maintenance work uses on 9/18/2013 for repair of of bed in room 306; on eded repair at the head of bed 0/2013 a wheelchair request; he closet door was off track ed a light bulb. The visor did not indicate there | {F 2 | 4. | The facility's Maintenance Director will pronothly reports to the facility's Perform Improvement Committee on 1. A summit month's Work Orders, identifying any to timeline rates for completion; and, 2. The facility Weekly Rounds, including entrends and actions taken. Completed 10 Ongoing. | nance ary of the ends and ne results of vironmental | 10/8/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | DISTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|------------------------------------|--|---------------------|--|----------------------------|--|
| | | 345143 | B. WING | | 10/07/2013 | |
| | OVIDER OR SUPPLIER CARE AND REHABI | ILITATION CENTER | 900 | EET ADDRESS, CITY, STATE, ZIP CODE W DOLPHIN ST ER CITY, NC 27344 | 10.0112010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE COMPLETION | |
| {F 253} | Continued From pa | age 14 | {F 253} | | 1 | |
| | | ur was conducted with the | (i 200) | | • | |
| h . | | | : | | | |
| | | ing the interior of residents ' | į | | • | |
| | | istrator did not have a problem | | | 1 | |
| | | elevision cable hanging out of 33 and reported he was aware | | | 1 | |
| | | • | • | | İ | |
| 1 | | or in room 311. During an | | | | |
| | | Administrator he revealed there lace and the facility address | : 1 | | | |
| | | | | | | |
| | • | e confronted with them. The swere done verbally and if not | | | | |
| | | made through a work order. | | | : | |
| | | | | | | |
| i e | | ould report anything they felt | | | | |
| | | port. The Administrators ne for completing work orders | | | | |
| | - | . Maintenance does not need a | | | | |
| | | h walls. The maintenance | | | | |
| | | itiate projects on his own, " just | | | | |
| | if he notices them | | 1 | | i i | |
| 6 | | | (5.000) | | | |
| | | CARE/SERVICES FOR | {F 309} | | ; | |
| SS=D | HIGHEST WELL E | SEING | | | - | |
| : | Each resident mur | of reactive and the facility must | ; | | | |
| | | st receive and the facility must sary care and services to attain | | | | |
| | | ghest practicable physical, | 1 | | į. | |
| İ | | nosocial well-being, in | i i | | ; | |
| | | he comprehensive assessment | , | | 1 | |
| • | and plan of care. | ne comprehensive assessment | 1 | | | |
| 1 | and plan or care. | | 1 | | | |
| | | | 1 : | | İ | |
| | | | | | | |
| | This REQUIREME | ENT is not met as evidenced | į | | l l | |
| | by: | | | | | |
| | . • | review, physician, nurse | ! | | | |
| | | and Emergency Medical | | | ! | |
| | , * | nterviews, the facility failed to | | | | |
| | | ss the need for medical | | | | |
| | | resident with a significant | ! | | • | |
| | | on; and failed to immediately | į | | | |

| CENTERS | S FOR MEDICARE & | MEDICAID SERVICES | | | | | OMB NO | . 0938-039 |
|--------------------------|--|---|---------------------------------------|------|----------|--|-------------------------------|---------------------------|
| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A BUILDING | | | RUCTION | (X3) DATE SURVEY COMPLETED | |
| | | | | | | | R- | ·C |
| | | 345143 | B. WNG | | | | 10/0 | 07/2013 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | ST | REET. | ADDRESS, CITY, STATE, ZIP CODE | | |
| SILER CIT | Y CARE AND REHABIL | ITATION CENTER | | 1 | | OLPHIN ST | | |
| | | | | ا | ILEK (| CITY, NC 27344 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | IX | : | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (XS) COMPLETIO DATE |
| {F 309} | Continued From pag | ne 15 | (E | 309} | : ! a | Resident #188 was admitted 10/3/12 v | with the | |
| | | | ξ | 000, | 1. | diagnosis of end stage renal disease re | | |
| | initiate emergency medical services for 1 of 4 residents (Resident #188) reviewed for change of | | | | | hemodialysis three times a week, gene | eralized | |
| | condition. | wroof reviewed for orderige of | | | | weakness requiring physical therapy a | | |
| | Condition | | į. | | ! | occupational therapy, Cornelia deLang | | i . |
| | Immediate Jeopardy | began on 2/7/13 when | | | | syndrome, Gout, hypertension, dyslipi | | |
| | facility staff became aware of Resident #188's | | 1 | | į | asthma, hypothyroidism, obstructive s | | |
| | acute change in con | dition including: lethargy, | | | | apnea, and obesity. Resident #188 wa | as noted | |
| | periodic thrashing, n | noaning, and elevated blood | | | 1 - | at 2:30 a.m. on 2/7/13 as being nonve | rbal | |
| | sugar, failed to iden | tify and assess her need for | i | | | and fluttering eyelids. Nursing assista | | |
| | emergency medical | interventions, and delayed | | | | reported this to the nurse. Nurse ass | assed | |
| | calling EMS for 30 n | ninutes after acute change in | | | | resident as being lethargic, both eyes | | |
| | condition was recog | nized (receiving hospital was | | | | and matted with yellowish green mat | ter, | |
| | approximately an ho | our away). | | | : | cheeks flushed and warm, temperatu | | |
| | | | | | | and noted to be 100.6, blood pressur | | |
| | | began on 2/7/2013 and was | | | : | 100/60, pulse 66, respiration 20, resi | | |
| | identified on 9/20/13 | 3 at 1:40 PM. | | | : | thrashing both arm s and moaning du | ıring | |
| | | | | | ! | examination, oxygen saturation 84%, | nasal | |
| | | ility's credible allegation was | 1 | | | cannula reapplied, oxygen stats incre | ased to | |
| | | 13. Residents on all halls | | | | 98%. Nurse checked finger stick bloc | | |
| | * | and 500) in the facility | | | 1 | and read high. At 3:30 a.m. tempera | ture | |
| | | ved and observations were | i | | • | recheck 99.1, no nausea or vomiting | . On | 1 |
| | | ents who had changes in | | | İ | 2/7/13 at 9:45 a.m. vital signs were | 40 | į |
| | conditions. The obs | | | | } | temperature 98.6, pulse 60, respirat | | |
| | | iated with change in | i | | į | blood pressure 90/52, oxygen satura | | |
| | | porting/communication o shift, staff documentation of | | | į | resident noted to be unresponsive, s | Kili is ury | |
| | | in condition in accordance with | | | ! | to touch, moans with movement, lui | | : |
| | _ | eveloped guidelines/tools | ŀ | | i | clear, finger stick blood sugar readin | g 5/. | ; |
| | | R (Situation, Background, | : | | | Nurse Practitioner notified of reside | | |
| | Assessment and | · (Ottochori Duonground) | \$ | | į | condition at 10:30 a.m., give order t transport to hospital for evaluation. | | l I |
| | | Request)/Change in Condition | 1 | | 1 | responsible party was call at 9:45 a. | | l |
| | | for all residents from 9/21/13 | į | | 1 | responsible party was call at 9:45 a. 2:45 p.m. but license nurse unable t | o contact | |
| | -10/7/13 were revie | | | | ; | as no one answered the phone. | Contact | 1 |
| | Record reviews we | re completed to verify the | 1 | | | | | |
| | | the assessment tools and the | į | | 1 | | | |
| | | of staff communication | | | | | | |
| | | change of condition use of the | ; | | ļ | | | |
| | | ol and glucometer training with | ; | | i | | | |

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| CENTER | S FOR MEDICARE | & MEDICAID SERVICES | | | <u>O</u> N | <u>VB NO. 0938-0</u> | |
|--------------------------|---|---|-----------------------|--------|--|-------------------------------|--|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | | INSTRUCTION (X: | (X3) DATE SURVEY COMPLETED | |
| | | | | | | | |
| | | 345143 | B. WNG | | | 10/07/2013 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STRE | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 900 (| W DOLPHIN ST | | |
| SILERCIT | Y CARE AND REHAB | ILITATION CENTER | | SILE | ER CITY, NC 27344 | | |
| O(A) ID | SHMMARY | STATEMENT OF DEFICIENCIES | 1D | · | PROVIDER'S PLAN OF CORRECTION | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | PREF TAG | IX : | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLET DATE | |
| {F 309} | Continued From page | age 16 | · {F: | 309}: | | | |
| (, ,,,, | all shifts of medica | | : " | 0007 | 2. Residents residing in the Facility had their | | |
| | ali Sililis di Hiculta | u stan. | : | ÷ | medical records reviewed for any docume | | |
| | Stoff intensions we | ere conducted with all three shift | ļ | | change of condition on 9/20/13 by Direct | ented | |
| | | mentation of the newly | 1 | ! | Nurses, Assistant Director of Nurses, and | OI OI | |
| | | Situation, Background, | | • | shift registered nurse. During the review of | tirst | |
| | | ommendation/Request) form, | ; | | resident noted to have complained of pair | one | |
| | | nange in Condition form, | ! | | 9/20/13, in her legs, the resident was asse | n on | |
| | | ng ,Early Warning " Stop and | | | by the Assistant Director of Nurses and | assea | |
| | | SBAR form indicating review of | | | physician called with new orders for x ray | | |
| | | nd knowledge of the resident | : | • | lab work to be obtained. | and 4 20 | |
| | i contract of the contract of | on had been completed by | | | ino work to be obtained. | • | |
| | • | redible Allegation. Direct Care, | i | - | | | |
| | • | Staff interviews were | i | | 3. 38 of 38 licensed nurses were re-educate | | |
| | | y current staff and agency staff | | | Nursing Administration by 9/21/13 on th | • | |
| | | ced in the new systemic | | | Interventions to Reduce Acute Care Tran | | |
| | | ocols. The completion date for | | : | | • | |
| | | nursing and nursing assistant | | | (INTERACT) Tools including the Care Path | | |
| | became effective | - | | 1 | guidelines for physician notification, whi | | |
| | bcoame checare | 10/11/0. | I | F . | notification by telephone and after office | | |
| | The Quality Assur | rance Audit reports since | | | notify by telephone the on-call physician | | |
| | | 0/6/13 were reviewed along with | } | | templates which include but not limited | | |
| | | documentation of the Credible | | | abnormal pain, abnormal pulse, abrasion | A, | |
| | | apliance, to verify the | | | C. C. and lethores weakness | ss of | |
| | | f the facility's Credible Allegation | | | agitation, confusion and lethargy, weakness | | |
| | of Compliance. | | 1 | | arm or leg, cardio-pulmonary arrest, cough | | |
| | | | | | diabetes, fall and hematuria. Any licensed nurses who were unavailable for re-educa | ition ! | |
| | The survey found | that immediate jeopardy was | | i | | | |
| | • | area of Assessment of Resident | | 1 | will not be allowed to work until the educa | auon . | |
| | | tion as a result of lethargy, | | ļ į | is completed. Licensed nurses were re- | nen | |
| | • | g, moaning, and elevated blood | | ļ | educated 9/21/13 on solving problems where the shapes manifesting system includes | | |
| | | 9/21/13. The facility remains | į | ļ | using the glucose monitoring system inclu | | |
| | | e at the D level (No Actual Harm | | 1 | the codes that may appear: "H!" indicates | | |
| | • | More than Minimal Harm that is | 1 | | the blood glucose reading is above 600 m. | | |
| | i | eopardy), in order to continue | ! | | and "Lo" blood glucose reading is below 2 | | |
| | | of the process and monitor | | 1 | mg/dl. Education included that when the | onds | |
| | systems. | , | | i | codes appear they should wash and dry h | | |
| | | | | ĺ | of the resident and repeat the test with a | new | |
| | Findings include | ed: | | | test strip. If results still are "Hi" or "Lo" co | | |
| | | | | i | physician immediately by telephone. The | 7/2. | |

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | OMB N | <u>IO. 0938-039</u> |
|--------------------------|---------------------------------------|---|------------------------|--|----------------|----------------------------|
| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | TIPLE CONSTRUCTION | COL | TE SURVEY MPLETED |
| | | 345143 | B. WING | | | R-G |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODI | | 0/0//2013 |
| | | | | 900 W DOLPHIN ST | - | |
| SILER CIT | Y CARE AND REHABIL | ITATION CENTER | | SILER CITY, NC 27344 | | |
| | | | | <u> </u> | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | SHOULD BE | (X5) COMPLETION DATE |
| {F 309} | . Continued From pag | e 17 | ı JE | 309} Facility uses only one brand of g | lucometer. In | |
| (, 000) | • • | | , Ji | the future, if the brand of glucor | | |
| | | originally admitted to the not readmitted on 12/28/12. | | changed, licensed nurses will be | | |
| | | ded hypertension, diabetes, | | usage from the manual that is p | | |
| | - | enal disease, clostridium | ; | the glucometer. The manuals fo | | |
| | - | kness, muscle wasting, | ! | used glucometer are located on | | |
| | dialysis, and asthma | | | medication cart. Starting 9/21/ | | • |
| | anaryone, and adding | •• | 1 | Administrative Nurses will comp | | |
| | There was a physici | an order dated 12/28/12 for | | competencies on licensed nurse | s for glucose | |
| | | (mg) orally, as needed every | | readings weekly for one month, | then monthly | |
| | 4-6 hours for nause: | · | * | for two months. The Staff Devel | opment | |
| | | • | | Coordinator will provide educat | ion on the | |
| | The January Medica | ation Administration Record | : | INTERACT Tool beginning on 9/2 | 20/13 and will | |
| | (MAR) indicated Re | sident #188 received 17 | , | continue weekly until all license | d nurses can | |
| | doses of Zofran for | nausea. | | demonstrate understanding thr | ough | |
| | | | | competency testing. Licensed n | | |
| | | ian order dated 1/2/13 for | | the education record at the tim | • – | |
| | | ally, as needed every 6 hours | | the competencies and a copy of | | |
| | for pain. | | • | competencies will be placed in t | | |
| | | | | employee education file located | | |
| | | num Data Set (MDS) | : | Development Coordinator's offi | | |
| | i | 1/4/13 indicated the resident | ! | Nurses and/or Assistant Directo | | İ |
| | | ct, did not reject care, | | review the INTERACT Tools wee | * | i |
| | , , | ssessment, needed extensive | | consistency and accuracy. A mo | | |
| | was on oxygen, and | vities of daily living (ADLs), | ī | was developed to audit the con | | |
| | was on oxygen, and | received dialysis. | | accuracy of the INTERACT Tools | | 9/21/1 |
| | The social work not | te dated 1/4/13 indicated the | 1 | maintained in the Director of N | maes onice. | -11 46+111 |
| | | irium or behaviors, was tired | | ÷ | | |
| | | casional lack of interest in | 1 | | | : |
| | | derstood and understands." | i | | | : |
| | | | 1 | 1 | | 1 |
| | The Medication Adr | ministration Record dated | | | | |
| | · · · · · · · · · · · · · · · · · · · | Resident #188 was given | | ! • | | |
| | | y mouth once for pain. There | | | | į |
| | | tion indicating location of pain | 1 | | | 1 |
| | or if pain medicatio | | | | | |
| | The nurse's note d | ated 1/21/13 indicated | į | <u>†</u> | | : |
| | | decreased nausea after her | ĺ | | | |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | l, | (3) DATE SURVEY COMPLETED |
|--------------------------|---|---|---------------------|--|---|
| | | 345143 | B. WING | | R-C |
| | OVIDER OR SUPPLIER | LITATION CENTER | 900 | EET ADDRESS, CITY, STATE, ZIP CODE W DOLPHIN ST ER CITY, NC 27344 | 10/07/2013 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION E DATE |
| {F 309} | discontinued on 1/1 The nurse's note destated, "[Resident] of [appointment] for [u [Physician] in facility regarding] refusal, despite discussion. The physician assess "Patient is being see examination. Patient with nursing staff. Patient expresses in Patient is doing we Diagnoses included mellitus without menot stated as uncontrolled to the pain medication. The Medication Addated 1/30/13 indiction 5-500mg by was no documentation or if pain medication. A review of the February 2013 review of the Bee February 2013 review behaviors. The nurse's note of indicated the residual degrees, was alerted. | ated 1/24/13 at 9:00 am continues to refuse apper gastrointestinal exam), and in to assess [resident [Resident] continues to refuse with [physician]." assment dated 1/24/13 stated, are for routine monthly at a case and care discussed Patient is seen and examined. The concerns or new issues. It and no complaints." d: "hypertension, diabetes antion of complication, type II, antrolled." ministration Record (MAR) cated Resident #188 was given by mouth once for pain. There ation indicating location of pain | {F 309} | 50 of 57 Certified Nursing Assistants were reducated on 9/21/13 on the INTERACT Earl Warning Tool "Stop and Watch" that asks to Nursing Assistants to circle the noted resid change and discuss with their charge licens nurse. Changes listed are Seems different to usual, Talks or communicates less than usual, Participated in Activities less than usual, Participated in Activities less than usual, Aless than usual, Drank less than usual, Welchange, Agitated or nervous more than usual, tried, weak, confused or drowsy, Change skin color or condition and Help with walk transferring, toileting more than usual. At Certified Nursing Assistants who are unavailable for re-education will not be allowed to work until the education is completed. Starting 9/21/13, Competence the use of the Early Warning Tool will be completed on 15 Certified Nursing Assistances the three shifts weekly for one modern Certified Nursing Assistants will sign the education record at the time of completic competencies and a copy of the competencie | he ent se chan rai, te ight rail, in ring, ry y for ents enties |

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| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | , | | | OMB NO. | 0938-0391 |
|--------------------------|------------------------------|---|-----------------------|------|--|-----------------------|----------------------------|
| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | | STRUCTION | (X3) DATE S COMPLI | ETED |
| ···- | | 245442 | B. WING | | | R-(| |
| | | 345143 | b. WING | 200 | | _ 10/0 | 7/2013 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | 1 | T ADDRESS, CITY, STATE, ZIP CODE | | |
| SILER CIT | Y CARE AND REHABIL | LITATION CENTER | | ł | DOLPHIN ST CITY, NC 27344 | | |
| (X4) ID PREFIX TAG | (ÉACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| ₹E 300} | Continued From pag | no 10 | (E | 300) | | | |
| (1 208) | | | {r · | 309} | A L. C. C. C. Strong and H. C. C. C. | 24 hour | |
| 1 | • | for a fever reducer, no | | | 4. Administrative Nursing will review | | |
| | | erventions for the resident's | : | | report and conduct resident roun | | |
| | | re, or reassessment of | | | the residents for change daily for | | : |
| | Resident #188's ten | nperature on 2/6/13. | : | | weekly for 60-days. The facility do | | |
| | The mount of all | ated 2/6/42 at 40:20 am | | | monitoring tool to be used which | | |
| <u> </u> | | ated 2/6/13 at 10:30 am | | 1 | appearance of resident, facial exp | | |
| | | ent was transported to dialysis | | | speech, odors, breathing, alertne | .SS, CORHOIC | |
| | with no complaints. | | | | level, extremities/skin color, | d squipment | |
| | The Cohmon MAD | indicated Decident #199 | | | posture/positioning, gait, medica | | |
| | | indicated Resident #188 | | | and safety. This monitoring tool | | |
| | | ng orally for nausea on 2/6/13 | | | routine rounds, episodic events a | | |
| | at 5:00 pm. | | | | admissions with any noted chang | | |
| | The Change of Co. | ndition Decumentation form | | ' | is to be assessed more thorough | | |
| | | ndition Documentation form, | 1 | | but not limited to vital signs, lun | • | ļ |
| | • | e #1 and dated 2/7/13, stated, | | | bowel sounds. The Director of N | | |
|] | | Aide #1] reported resident | | | present to the Performance Imp | | |
| | | tering eye lids. Nurse noted | | | Committee the results of the mo | | |
| | | both eyes reddened [with] | | | medical records for notification, | | |
| | | atter. Cheeks flushed [and] | į | [| license nurses competencies for | | |
| ļ | • | S. Periodically thrashing both | į | , | physicians, assessing change of o | | alsoliz |
| | | nation [and] moaning [with] cat ' s meow. Nasal cannula | r | : | residents and troubleshooting g | lucometer for | 9/21/13 Orgoin |
| | · · | | | į | 90-days. | | OAMOLV |
| | | oxygen saturation] 84%. at] 4 L [with oxygen saturation | | | | | |
| | | . Bipap replaced. Cleansed | | | | | |
| | | atter. Gave Vicodin 5-500mg | ! | | | | |
| | | due to) decreased [level of | ŀ | | | | ; |
| | . • • • • | Checked blood sugar due to | | ; | | | |
| | | [with] reading HI. Decreased | i i | į | | | ! |
| | , , , | it said 2-3 words but still not | i i | 1 | | | ŀ |
| | | 3:45 am [temperature] 99.1. | | | | | , 1 |
| | | miting. Continue to moan [and] | | 1 | | | : |
| | | at times." Vitals signs were | | 1 | | | |
| | · | 30 am as: blood pressure | | i | | | 1 |
| | | temperature 100.6, respirations | | 1 | | | ! |
| | 20, and blood sug | | | ı | | | |
| | 1 , | | 1 | | | | |
| 1 | The Medication Ad | dministration Record (MAR) | ! | | | | i |
| 1 | | ated at 2:30 am Resident #188 | i | • | | | 1 |

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| STATEMENT (| OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI | LE CONSTRUCTION | (X3) | 3 NO. 0938-039 DATE SURVEY COMPLETED |
|--------------------------|---|---|---------------------|--|--------------------------------------|--|
| ~ | | | | | | R-C |
| | | 345143 | B. WNG | | | 10/07/2013 |
| | ROVIDER OR SUPPLIER TY CARE AND REHABI | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZII 900 W DOLPHIN ST SILER CITY, NC 27344 | PCODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETIC DATE |
| {F 309} | Continued From pa | ge 20 | , {F 30 | 9} | | |
| | was given Vicodin ! | 5-500mg by mouth once for | | | | |
| | generalized pain. T | | 4 | 1 | | |
| | - | Sheet indicated the resident | : | 1 | | • |
| | | aired and in mild pain at 2:30 | | • | | 4 |
| | | impaired and in no pain at | | , | | • |
| | 6:30 am. | | | ! | | |
| | During a telephone | interview with Nurse Aide #1 | | | | |
| | | am, when asked about | : | į. | | |
| | : | ual mental status and how she | • | | | |
| | | 7/13, she stated, "That night | : | \$ | | |
| | | ne was in a lot of pain. She | Ì | * # | | |
| | | oout pain that night and was | | | | |
| | | she was waking up other | | | | ÷ |
| | | ed it to the nurse (Nurse #1). | 1 | : | | |
| | _ | not acting like herself that | 1 | i F | | |
| | night." | The detailing into the total disc. | : | : | | 1 |
| | During a telephone | interview with Nurse #1 on | , | | | : |
| | | n, she stated, "I think | ı | 1 | | 1 |
| | | pehavior led me to check her | | | | • |
| | | wasn't really talking. This was | | | | 1 |
| | | the usually spoke in full | ı | i | | F |
| | | s easy to understand. I took | 1 | į | | • |
| | | a vital sign. 'HI' would mean it | † : | | | |
| | | e was not diagnosed with | 1 | 1 | | 1 |
| | | checked because she was | 1 | | | , |
| | | abetics with high sugar. I did | 1 | 1 | | |
| | | ar with another machine. I | | ; | | 1 |
| | ; cannot remember | if I ran controls on the | | | | r |
| | machine. She sta | rted acting normal about an | | | | : |
| | | ntaining eye contact so I faxed | į | | | |
| | | nge in condition form. I did not | 1 | | | 1 |
| | | started acting better. I did not | 1 | | | |
| | | sulin or give any insulin or other | | ! | | |
| | | to her high blood sugar. If her | 1 | | | į |
| | | mproved, I would have called | ı | | | ! |
| | | remember writing a note about | ! | | | |
| | her condition impr | oving. I did not recheck her | 1 | <u>.</u> | | |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUİLDI | | STRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|-------------------------------------|---|-------------------|---------|---|-------------------------------|
| | | | | | | R-C |
| | | 345143 | B. WNG | | · | 10/07/2013 |
| | OVIDER OR SUPPLIER CARE AND REHABIL | ITATION CENTER | : | 900 W I | FADDRESS, CITY, STATE, ZIP CODE DOLPHIN ST CITY, NC 27344 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENT | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLET |
| {F 309} | Continued From pag | ne 21 | · {F: | 309} | | |
| | | e she did not have an order | ,, | , | | |
| | ~ | onitoring] or a diabetes | i | | | |
| | diagnosis." | iomomy or a diasotos | | : | | |
| : | alaghosis. | | • | : | | |
| | Other than the Char | age of Condition | į | | | |
| | | re were no other nurse's | | 1 | | |
| | • | sident #188 from 2/6/13 at | | | | • |
| | 10:30 am to 2/7/13 | at 9:45 am. | | | | |
| • | Nurse #2's note dat | ed 2/7/13 at 9:45 am stated, | : | | | |
| | | 6, [pulse] 60, [respirations] 18, | | | | |
| | | /52, [oxygen saturation] 84%. | | | | |
| | | sive. Opens eyes then roll | 1 | | | |
| | | is with movement of any kind | • | | | |
| | | verbalize anything. [Blood | | | | 1 |
| | | n facility accucheck machine. | | | | • |
| | | this a.m. Hands cold to touch." | : | | | |
| | During an interview | on 9/19/13 at 12:05 pm, | | ; | | : |
| | | ler blood sugar was low that | | | | |
| | | as sent to the [emergency | | | | : |
| | | report from [Nurse #1] that | 4 | į | | |
| | | erent and her blood sugars | į | | | |
| | were elevated. [Nu | urse #1) said she filled out a | 1 | : | | , |
| | Change In Condition | on form. When you fill out the | | ì | | |
| | , form, you automati | cally notify the physician. The | : | : | | |
| | | riors that morning. She was | ÷ † | | | |
| | | nd oriented and would answer | | | | į |
| | | ately. She took her medicine | (| į | | |
| | | g but didn't eat breakfast. | : | i | | : |
| | | er after breakfast, she was not | <u>;</u> | ! | | i |
| | | uch as before breakfast so I | | 1 | | į |
| | | sugar. She wouldn't respond | 1 | i | | 1 1 |
| | | me. I know [Nurse #1] didn't | 1 | ! | | |
| | | cause we would have to have | i | • | | 1 |
| | | don't recall [Nurse #1] saying n she had filled out the change | 1 | 1 | | |
| | in condition form." | n and had thed out the change | : | į. | | |

| OLIVILIV | OT OR WILDIO/ INE G | INCDIONIO GENVICES | 1 | | OWD NO. 0936-0391 |
|--------------------------|--|---|------------------------------|--|---|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | ECONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | | | | R-C |
| | | 345143 | B. WNG | | 10/07/2013 |
| | ROVIDER OR SUPPLIER Y CARE AND REHABIL | ITATION CENTER | 9 | STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN ST SILER CITY, NC 27344 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY 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) | JLD BE COMPLETION |
| {F 309} | Continued From pag | ne 22 | {F 309 | `````````````````````````````````````` | |
| , | | ated 2/7/13 at 10:14 am | į, 000 | , | |
| | • | ergency department] for | ii. | 1 | |
| | [evaluation] unconsc | | ŧ | | |
| | The nurse's note da | ted 2/7/13 at 10:15 am | - | • | |
| | | ed supervisor at 9:45 am that | | | l l |
| | <u>-</u> | sponsive. Assessed [patient] | | | 1 |
| | | f consciousness] noted. | | | 1 |
| | Pupils equal, reactive | - | | | |
| | | 30 | | | |
| | Nurse #2's note dat | ed 2/7/13 at 10:30 am | | : | |
| | indicated Emergence | cy Medical Services (EMS) | | | |
| | _ | transport the resident to the | | | |
| | • | rse Practitioner was notified. | | ÷ | |
| | | | | | |
| | The Emergency Me | edical Service (EMS) transport | | | |
| | | stated, "Per nursing staff at | | | |
| | nursing home, [Res | | | | |
| | | ased [level of consciousness] | | | |
| | _ | a dialysis [patient] and | | | 1 |
| | | dent diabetic]. She had her | : | ! | i de la companya de la companya de la companya de la companya de la companya de la companya de la companya de |
| 1 | - | hen early this [morning] | | | |
| | | an experiencing decreased | | : | 1 |
|] | | ness] with fever. Per nurse her | | : | ı |
| 1 | - | el] at that time was over 400. | ; | | |
| | | sident] is not responding. Lies | : | | |
| | | d moans (no words). Nursing | f | | i i |
| | | e chief complaint indicated on | | | • |
| | | responsive patient. Duration: 9 | 1 | : | |
| | | | ' | : | |
| | | gnosis was "Altered level of | | | I |
| | consciousness, Dia | soetic symptoms. | | † | i |
| | A review of the EM | S assessment, dated 2/7/13 | : | 1 | 1 |
| Ì | indicated: | to december added 211110 | i . | | |
| | At 10:18 am EMS | received call | 1 | <u> </u> | |
| | EMS arrived at 10: | | i | | |
| | | z4 am. esident was agitated and | ! | i | • |
| | - | - | ì | | • |
| | | open but does not converse. Individual yells", decreased level of | ļ | | : |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | | STRUCTION . | (X3) DATE SURVEY COMPLETED | |
|--------------------------|----------------------------|---|--------------------|---------|--|-------------------------------|--|
| | | 345143 | B. WNG | | | R-C 10/07/2013 | |
| | OVIDER OR SUPPLIER | ITATION CENTER | | 900 W I | FADDRESS, CITY, STATE, ZIP CODE DOLPHIN ST CITY, NC 27344 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLET | |
| {F 309} | Continued From page | ge 23 | {F3 | (90) | • | : | |
| | consciousness, puls | se 112, blood pressure | • | • | | | |
| | 104/80, and had a l | · · · · · · · · · · · · · · · · · · · | | | | | |
| | | gave an intramuscular | | | | | |
| : | injection of Glucago | | • | i | | | |
| | | sident's blood glucose was | | | | | |
| | | 20. Vascular access was | | | | | |
| | started at 10:45 am | | • | | | | |
| | At 10:48 am, Dextro | | | | | | |
| | | gh the vascular access. | 1 | ï | | | |
| | | sident's blood glucose was | | | | • | |
| | rechecked and was | - | | | | | |
| | At 11:05 am, there | was no change in the | 1 | | | | |
| | | . She continued to not | • | | | | |
| | respond, yell, and i | noan. | | | | • | |
| | | sident's blood glucose was | • | | | | |
| | rechecked and was | s 200. | ŧ | | | | |
| | At 11:45 am, the re | sident was released to the | | | | | |
| | care of the emerge | ency department and there was | 1 | | | | |
| | _ | ent] status throughout EMS | | : | | | |
| | care." | , | | İ | | : | |
| | i During a telephone | interview with the EMS | | | | ÷ | |
| | | 2/13 at 5:40 pm, he indicated | i | • | | İ | |
| | | an EMS report was "the | | 1 | | ; | |
| | | signs and symptoms had | | ł | | | |
| | | or to EMS being called." | 3 | ; | | ! | |
| | A review of the em | ergency department | i • | į | | | |
| | assessment, dated | d 2/7/13 at 11:51 am indicated | | 1 | | | |
| | Resident #188 wa | s anxious, appeared to be in | ļ | | | | |
| | | , had a blood pressure of | : | İ | | | |
| | · | of 120, respiratory rate of 26, | 1 | ! | | | |
| | | oxygen saturation of 96% on 2 | | i | | i | |
| | | ad a soft, nontender abdomen, | | : | | 1 | |
| | | nfused, combative and | | | | | |
| | | son, place and time.", had | Ì | : | | į. | |
| | incoherent respon | ses, and inappropriate speech. | 1 | : | | : | |
| | A roudour of the he | spital discharge summary, | : | į | | | |

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | RVICES | | | OMB NO. 0938-039 | | |
|--------------------------|---------------------------|---|------------------------|--------|--|-------------------------------|--|--|
| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | | STRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | | Y BOILDI | | | | | |
| | | 245412 | B. WNG | | | R-C | | |
| | | 345143 | D. WING | | | 10/07/2013 | | |
| NAME OF PE | ROVIDER OR SUPPLIER | | | l | TADDRESS, CITY, STATE, ZIP CODE | | | |
| SILER CIT | Y CARE AND REHABIL | ITATION CENTER | | 900 W | DOLPHIN ST | | | |
| | | | | SILER | CITY, NC 27344 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLETION | | |
| (E 000) | | | : | | · | | | |
| {F 309} | Continued From pa | | · {F: | 309} | | | | |
| | | cated Resident #188 was | | | | | | |
| | | and passed away on 2/11/13 | | | | | | |
| | | ary arrest secondary to septic | | | | | | |
| | | rge summary stated, "In [the | | | | | | |
| | | nent] [patient] was found to be | | ; | | | | |
| | | nsensically, and had multiple | | | | | | |
| | | was subsequently intubated | | | | | | |
| | | medical [intensive care unit]. | | | | | | |
| | | esuscitated, requiring | | | | | | |
| | | ort (medication to maintain her | İ | | | | | |
| | • | nd a surgical consultation was | | | | • | | |
| | | evidence of peritonitis | | | | | | |
| | | e lining of the abdomen), an | ! | | | | | |
| | | omy (incision to examine the | | | | | | |
| | | ninal cavity) was performed, | | i | | | | |
| | | ed bowel perforation. Bowel | | | | | | |
| | | ormed and the patient was | | ; | | : | | |
| | | surgical intensive care unit. | | : | | | | |
| | | ots at resuscitation and | | • | | | | |
| | | unsuccessful. Abdominal | ! | | | | | |
| | compartment synd | • | į | | | , | | |
| | | essure) was recognized and a | ' | 1 | | | | |
| | - | y (incision into the abdominal | 1 | • | | i | | |
| | cavity) was perforr | | i | | | | | |
| | · | essure. However, the patient | | ! | | ! | | |
| | was not able to rec | cover, and she expired." | i | • | | 1 | | |
| | During an interviev | w on 9/19/13 at 12:30 pm, the | † : | | | | | |
| | | g stated,"Intermittant [blood | , | 1 | | | | |
| | | g] would be documented in the | 1 | ļ | | | | |
| | | ause it would not be on the | 1 | | | | | |
| | | ig said 'HI', I would expect the | 1 | i : | | Ì | | |
| | | rechecked. If it remained 'HI', I | : | | | | | |
| | | physician to be contacted, | r | | | ļ | | |
| | | resident's condition and level of | | 1 | | • | | |
| | | a change for that particular | | | | | | |
| | | came in the nurse told me | ļ | ļ | | ì | | |
| | | in mental status and that the | 1 | 1 | - | | | |
| | _ | r was called and EMS was | | į | | | | |

| OLIVILIV | or or mediorate | A MEDIONID OLIVIOLO | | | OWID NO. 0930-038 |
|--------------------------|------------------------------|---|---------------------|--|-------------------------------|
| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE COI | NSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 345143 | B, WNG | | R-C |
| NAME OF DE | OVERTO OF CURRILIED | 313173 | 1 - | ET ADDRESS OUTVIETATE ZID CODE | 1 10/07/2013 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | ET ADDRESS, CITY, STATE, ZIP CODE | |
| SILER CIT | Y CARE AND REHAE | BILITATION CENTER | 4 | V DOLPHIN ST | |
| | | | SILE | R CITY, NC 27344 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | ' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE COMPLETIO |
| | , | | * | 1, 2 | |
| {F 309} | Continued From p | age 25 | {F 309} | | |
| | called." The DON | indicated that had she known | | | |
| | of the resident's co | ondition, including change in | | | |
| | behavior and elev | ated blood sugar, at 2:30 am | | | |
| | | alled EMS. She further | | | |
| | | nge in behavior and low blood | : | | • |
| | | d in transport to the hospital on | | | |
| | | n would have been the same | | | |
| | • | rt the resident on 2/7/13 at 2:30 | | | |
| | | l a documented change in | 1 | | |
| | behavior and high | ı blood sugar. | | | |
| | During an intervie | w with the Assistant Director of | T | | |
| | - | on 9/19/13 at 11:39 am, she | | | |
| | | ras an elevated blood sugar, | | | |
| | | doctor's note stating to give | | | |
| | | ne was in distress and a blood | i i | | |
| | sugar was checke | ed, it would be documented in | • | • | |
| | the nurse's notes | . I see a blood sugar of 57 on | | | |
| | | ee any documentation of an | i | | : |
| | | gar." "The night nurse would | | | |
| | | nange in condition to the | | | |
| | physician. We do | n't keep the face sheets as part | 1 | | |
| | | here is no way to know what | | | • |
| | time the physicia | n was notified by fax. There is | ÷ | | : |
| | an on-call so I wo | ould expect the physician would | 1 | | |
| | | l, not just a fax sent, since it was | į | | i |
| | 2:30 in the morni | ng when the change occurred." | i I | | |
| | During a telepho | ne interview with the Nurse | | | i |
| | | /19/13 at 3:39 pm, she indicated | i | | ! |
| | | e office, and not in the facility, | | | |
| | | nediately receive an incoming fax | | | |
| | | d, "If there is a change in a | 1 | | : |
| | | they should call the on-call | 1 | | |
| | | s always someone on call. That | 1 | | |
| ł | | n especially if the resident is | , | | |
| | | . Even if they can't contact a | | | |
| | | ould go ahead and call EMS with | ! | | 1 |
| | | ar and the resident being | i : | | |

| | | ND HUMAN SERVICES | | | | | ED: 10/09/2013 RM APPROVED |
|--------------------------|--|--|--------------------|--|--|---------|---|
| STATEMENT C | F DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | TIPLE CONSTRUCTION | | (X3) D/ | NO. 0938-0391 ATE SURVEY DMPLETED |
| | | 345143 | B. WING | | | | -R-C |
| | ROVIDER OR SUPPLIER Y CARE AND REHABI | LITATION CENTER | | STREET ADDRESS, 900 W DOLPHIN S SILER CITY, NC | | age . | 10/07/2013 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PR X (EACH | OVIDER'S PLAN OF CORRECT H CORRECTIVE ACTION SHOUR -REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| {F 309} | blood sugar is low a They should call the They should not was that may not even or remember that day sent out and I did no condition until after facility." During a telephone on 9/19/13 at 3:51 change in a resider should immediately on-call physician. I minute call back. They should be call my primary contact my cell phone. I caphysician indicated nurse should have am when the change of condition protocol and proceed. | ge 26 expectation is the same if the and they are symptomatic. e physician and call EMS. Set on a response from a fax get seen right away. I I was called and told she was ot receive the faxed change in she had already left the interview with the Physician pm, he stated, "If there is a not's condition, the facility or contact EMS and contact the My group policy is a 10-15. They should never wait. If the a change in condition form, ing the physician. They have it, secondary contact, and even an always be contacted." The land the physician at 2:30 ge in condition was recognized. If with the Administrator on the stated, "I would expect in ion for the nurse to follow dure and follow her nursing contact the physician and or | {F 3 | 309} | | | |
| | | | 1 | į | | | |

PRINTED: 10/09/2013

PRINTED: 10/25/2013 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION 1 - MAIN BUILDING 01 | (X3) DATE S COMPLI | |
|---------------------------------------|--|---|-------------------|---------|---|---|----------------------------|
| المرابة كالمرابية والمستخدلين والمراب | | 345143 | B. WING | | | 10/22 | 2/2013 |
| | PROVIDER OR SUPPLIER | ABILITATION CENTER | | 90 | REET ADDRESS, CITY, STATE, ZIP CODE 10 W DOLPHIN ST ILER CITY, NC 27344 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | DBE (| (X5) COMPLETION DATE |
| K 000 | This Life Safety C conducted as per at 42CFR 483.70(a Health Care section publications. This construction, one automatic sprinkle. The deficiencies dare as follows: NFPA 101 LIFE S Smoke barriers are least a one half he accordance with a terminate at an attended by fire-repanels and steel fiseparate compart floor. Dampers are penetrations of sine atting, ventilatin | ode(LSC) survey was The Code of Federal Register a); using the 2000 Existing on of the LSC and its referenced building is Type II (111) story, with a complete or system, letermined during the survey AFETY CODE STANDARD re constructed to provide at our fire resistance rating in a.3. Smoke barriers may rium wall. Windows are ated glazing or by wired glass rames. A minimum of two ments are provided on each e not required in duct noke barriers in fully ducted g, and air conditioning systems, 19.1.6.3, 19.1.6.4 is not met as evidenced by: vation on Tuesday 10/22/13 at 30 AM onward the following | K | 000 025 | Preparation and/or execution of this Plan of does not constitute admission or agreement provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The Correction is prepared and/or executed sole it is required by the provisions of federal and along the wall above the ceiling tile by the Maintenance staff in order to mare required fire resistance rating of the sm Completed 10/28/13 2. The facility's Maintenance staff conductins pection of all the facility's smoke waten and penetrations. Holes and penetrations sealed if discovered. Completed 11/30/3 3. The facility's Maintenance staff will convisual inspections of the facility's smoke holes and penetrations, for three montongoing quarterly visual inspections. Consider the facility's Performance on the facility's Performance in the facility's Performance in the facility on an ongoing basic performance improvement Committee monthly for and then quarterly on an ongoing basic performance improvement Committee recommendations as appropriate. Consider the facility's and Ongoing Performance Improvement Committee recommendations as appropriate. Consider the facility's and Ongoing TITLE | of the conclusions are Plan of hy because distate law. Official conclusions are Plan of hy because distate law. Official conclusions are sealed aintain the moke barrier. Ited a visual list for holes on were for the and then completed a report of wall ce three months s. The e will make | 11/30/13 |

a. U. ... Commenter

Administrator

18/13

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.

| K 025 Continue K 029 SS=F One hot fire-rate extingui and/or the app option is other sp doors. field-ap 48 inchpermitte This ST Based approx deficier 1) The was we closing did not 2) The latch a 3) The | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | (X3) DATE COMP | LETED |
|--|--|---|--|--|---|----------------------------|
| (X4) ID PREFIX TAG SEGUE K 025 Continue K 025 Continue 42 CFR NFPA 1 One hot fire-rate extingui and/or 1 the approption is other sp doors. field-ap 48 inchepermitte This ST Based approx deficier 1) The was we closing did not 2) The latch a 3) The | And the second s | 345143 | B. WING | | 10/2 | 2/2013 |
| K 025 Continue K 029 SS=F One hote fire-rate extingui and/or the approption is other spandors. field-ap 48 incher permitted This ST Based approx deficien 1) The was we closing did not 2) The latch a 3) The | | BILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN ST SILER CITY, NC 27344 | | |
| K 029 SS=F One hote fire-rate extingui and/or the approphion is other spreadors. field-ap 48 inches permitted This ST Based approx deficien 1) The was we closing did not 2) The latch a 3) The | (FACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| SS=F One hot fire-rate extingui and/or the appropriate of the stand of | Continued From pa | age 1 | K 02 | 5 | | |
| Based approx deficier 1) The was we closing did not 2) The latch a 3) The | One hour fire rated ire-rated doors) or extinguishing system and/or 19.3.5.4 prohe approved autooption is used, the other spaces by sidoors. Doors are field-applied prote 48 inches from the | r fire rated construction (with ¾ hour doors) or an approved automatic fire shing system in accordance with 8.4.1 9.3.5.4 protects hazardous areas. When oved automatic fire extinguishing system used, the areas are separated from aces by smoke resisting partitions and Doors are self-closing and non-rated or olied protective plates that do not exceed as from the bottom of the door are | | preventing the Central Supply Room 10/22/13. The corridor door to the ki repaired so that it will latch and seal replacement door between the kitch room had been ordered on 10/24/13 installed upon its arrival. The corrido Laundry Room was repaired so that i seal on 10/22/13. Completed 11/30/ | at it will latch and seal on 10/22/13. A coor between the kitchen and dining in ordered on 10/24/13 and will be lits arrival. The corridor door to the was repaired so that it will latch and 1/13. Completed 11/30/13 71/30 Ince staff inspected all facility doors on insure that they will latch and seal as | |
| 4) The close I | Based on observapproximately 8:3 deficiencies were 1) The corridor d was wedged oper closing. The cent did not close latch 2) The corridor d latch and seal. 3) The door betwroom did not latch 4) The corridor d close latch and s | oor to the central supply room preventing the door from tral supply room corridor door and seal. oor to the kitchen din not close ween the kitchen and dinning and was not in goood repair. oor to the laundry room did not eal. | K | 3. The facility's Maintenance staff will disspections of all facility doors, to en latch and seal, for one month and the ongoing. The facility's Staff Development Coom Maintenance Director/Safety Coordifacility staff education on fire safety importance of doors. Completed 11, 4. The Maintenance Director will present the results of the facility door insperfacility's Performance Improvement monthly for three months and then ongoing basis. The Performance Improvemental appropriate. Completed 11/7/13 and 1056 | en monthly rdinator and nator provided and the /22/13 ent a report of ctions to the Committee quarterly on an provement tions as | ก/รอ)เ |

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPLE | CONSTRUCTION | (X3) DATE | |
|--------------------------|---|--|-------------------|-------------|---|---|----------------------------|
| | F CORRECTION | IDENTIFICATION NUMBER: | | | 01 - MAIN BUILDING 01 | COMP | LETED |
| | | 345143 | B. WING | | | 10/2 | 2/2013_ |
| | ROVIDER OR SUPPLIER TY CARE AND REH | ABILITATION CENTER | | 90 | TREET ADDRESS, CITY, STATE, ZIP CODE DO W DOLPHIN ST ILER CITY, NC 27344 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .DBE | (X5) COMPLETION DATE |
| K 056 | If there is an autor installed in accord for the Installation provide complete building. The syst accordance with N Inspection, Testin Water-Based Fire supervised. There supply for the systems are equip | matic sprinkler system, it is ance with NFPA 13, Standard of Sprinkler Systems, to coverage for all portions of the tem is properly maintained in NFPA 25, Standard for the g, and Maintenance of Protection Systems. It is fully the is a reliable, adequate water tem. Required sprinkler oped with water flow and tamper re electrically connected to the | | 056 | The facility had a sprinkler head installed ryers in the laundry room. Completed heads in the kitchen and laundry room that they were clean and in good repairs sprinkler heads discovered to be in new will be replaced. Completed 11/30/13 The facility Maintenance staff checked heads in the bedroom closets for 18 in around the head. Completed 11/30/13 The facility Maintenance staff inspected sprinkler heads to ensure that they were in good repair. Any sprinkler heads dis in need of repair will be replaced. Com 11/30/13 | d the sprinkle to ensure r. Any ed of repair the sprinkler ch clearance d all facility re clean and covered to be | 11/30/12 |
| K 147 SS=f | Based on observapproximately 8:3 deficiencies were 1) A sprinkler he the dryers in the I 2) The sprinkler Laundry room we 3) Throughout thin the bedroom of clearance around coverage. 42 CFR 482.41(i) NFPA 101 LIFE SELECTRICAL WIRING A | ad will need to be added above aundry room. heads in the Kitchen and are not clean and in good repair. e facility in the sprinkler heads losets did not have the 18 inch I the head to allow for proper | | 〈 14 | The facility's Maintenance staff will insprinkler heads to ensure that they are good repair monthly and for 18 inch of three months and then quarterly ongo Completed 11/30/13 and Ongoing The Maintenance Director will present the results of the facility sprinkler heat to the facility's Performance Improver Committee monthly for three months quarterly on an ongoing basis. The Performance will make recommendations as appropriate. Con 11/7/2013 and Ongoing | e clean and in earance for ing. a report of d inspections nent and then formance | (1/38) |

| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ONSTRUCTION MAIN BUILDING 01 | (X3) DATE COMP | SURVEY LETED |
|--|---|---|-------------------|-------|--|--|----------------------------|
| NAME OF P | ROVIDER OR SUPPLIER | 345143 | B. WING | | EET ADDRESS, CITY, STATE, ZIP CODE | 10/2 | 2/2013 |
| NAME OF PROVIDER OR SUPPLIER SILER CITY CARE AND REHABILITATION CENTER | | | | | W DOLPHIN ST ER CITY, NC 27344 | | |
| (X4) ID PREFIX TAG | IFACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| K 147 | This STANDARD Based on observa approximately 8:30 deficiencies were 1) Throughout the outlet power strips resident rooms an | is not met as evidenced by: ation on Tuesday 10/22/13 at 3 AM onward the following noted: facility surge protector/multi were found to be in use in d/or patient care areas for nd other equipment. | K | 1. 2. | facility's surge protectors/multi outle for recommended Life Safety usage w weeks and monthly ongoing. Comple and Ongoing | checked each ower strip to requipment at 11/30/13 heck the t power strip weekly for four ted 11/23/13 has a report of ctor/multi outing's Performanc or three month asis. The ee will make | 11/23/13 |



 PRINTED: 10/25/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | | SURVEY | |
|--|--|--|-------------------|-----|---|---|----------------------------|
| | | 345143 | B. WING | | | | 2/2013 |
| | NAME OF PROVIDER OR SUPPLIER SILER CITY CARE AND REHABILITATION CENTER | | | 9 | TREET ADDRESS, CITY, STATE, ZIP CODI 00 W DOLPHIN ST SILER CITY, NC 27344 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENT | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAC | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| K 056 SS=D | conducted as per at 42CFR 483.70 Health Care secti publications. This construction, one automatic sprink! The deficiencies are as follows: NFPA 101 LIFE: If there is an autoinstalled in accorfor the Installatio provide complete building. The synaccordance with Inspection, Testi Water-Based Fir supervised. The supply for the synsystems are equiswitches, which building fire alarm. This STANDARI Based on observable approximately 8 deficiencies wer 1) The shower of | Code(LSC) survey was The Code of Federal Register (a); using the 2000 Existing on of the LSC and its referenced building is Type II (111) story, with a complete er system. determined during the survey SAFETY CODE STANDARD omatic sprinkler system, it is dance with NFPA 13, Standard n of Sprinkler Systems, to a coverage for all portions of the stem is properly maintained in NFPA 25, Standard for the ng, and Maintenance of e Protection Systems. It is fully re is a reliable, adequate water stem. Required sprinkler ipped with water flow and tamper are electrically connected to the m system. 19.3.5 D is not met as evidenced by: vation on Tuesday 10/22/13 at 30 AM onward the following e noted: urtain to the shower room on 500 | K | 000 | | curtains in the ver curtains uately 3 cusekeeping rooms to a had a mesh ned. Completed will check all the that they tately positioned athly ongoing, ling present a report wer curtain formance thly for three an ongoing | 11/15/13 |
| | mesh curtain to coverage of the | rtain installed at ceiling height. A is need in order to allow for shower stalls. | 10142711 | | Committee will make recommappropriate. Completed 11/7/ | endations as | (X6) DATE |

Any delicient 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.

PH

| CENTER | IS FUR MEDICARE | E & MEDICAID SERVICES | | | | OMB MA | . 0938-0391 |
|--|--|--|-------------------|-----|--|--|----------------------------|
| MD BLAN OF CORDECTION DESCRIPTION MUNICIPAL TO THE PROPERTY OF | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 | | | (X3) DATE SURVEY COMPLETED | | |
| | | 345143 | B. WING | | | 10/ | 22/2013 |
| | ROVIDER OR SUPPLIER | ABILITATION CENTER | | 90 | REET ADDRESS, CITY, STATE, ZIP CODE 0 W DOLPHIN ST LER CITY, NC 27344 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| K 056 | Continued From p | age 1 | K | 056 | | | |
| K 144 SS=D | 42 CFR 482.41(a NFPA 101 LIFE S |) AFETY CODE STANDARD | К | 144 | | | |
| 30=D | under load for 30 | Senerators are inspected weekly and exercised inder load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. | | | The facility Maintenance Director ar- the facility's vendor, Atlantic Power check the remote annunclator for properation. Completed 10/29/13 | Systems to | 10/29/13 |
| | | | | | 2. The facility's remote annunclator is o properly. Completed 11/8/13 | perating | 10/29/13 |
| | Based on observapproximately 8:3 deficiencies were 1) The remote an located on 500 harmony power Supplying | nunicator for the generator all did not show Emergency (EPS) load when the r was transferred from normal to r. | | | The facility will continue its monthly inspection of the remote annunciato the facility monthly fire alarm system emergency generators checks. Comp 11/30/13 and Ongoing The Maintenance Director will prese of the results of the facility remote a inspections to the facility's Performa improvement Committee monthly formonths and then quarterly on an one basis. The Performance improvement Committee will make recommendati appropriate. Completed 11/7/13 and | r as part of a and leted int a report nnunciator nce or three going it ons as | 11/30/13 |
| | | | | | | | |