| DEPARTMENT OF HEALT  | H AND HUMAN SERVICES  |                    |     | r  |      | APPROVED                   |
|--|---|--------------------|-----|--|------|----------------------------|
| CENTERS FOR MEDICAR  | E & MEDICAID SERVICES   |                    |     |  |      | . 0938-0391                |
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     | PLE CONSTRUCTION   | CON  | TE SURVEY<br>MPLETED       |
|  | 345325  | B. WING            | ;   |  |      | C<br>/ <b>14/2014</b>      |
| NAME OF PROVIDER OR SUPPLIEF   | २   | <u> </u>           |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |      |                            |
| CORNERSTONE NURSING  | AND REHABILITATION CENTER   |                    |     | 711 SUSAN TART ROAD BOX 948<br>DUNN, NC 28334  |      |                            |
| PREFIX (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE | (X5)<br>COMPLETION<br>DATE |
| been found guilty<br>mistreating reside<br>had a finding enter<br>registry concernin<br>of residents or mis<br>and report any knic<br>court of law again<br>indicate unfitness<br>other facility staff<br>or licensing autho<br>The facility must end<br>involving mistreated<br>including injuries of<br>misappropriation of<br>immediately to the<br>to other officials in<br>through establishes<br>State survey and of<br>The facility must h<br>violations are thor<br>prevent further po<br>investigation is in<br>The results of all i<br>to the administrate<br>representative and<br>with State law (ind<br>certification agend<br>incident, and if the | EPORT<br>NDIVIDUALS<br>not employ individuals who have<br>of abusing, neglecting, or<br>nts by a court of law; or have<br>red into the State nurse aide<br>g abuse, neglect, mistreatment<br>sappropriation of their property;<br>owledge it has of actions by a<br>st an employee, which would<br>for service as a nurse aide or<br>to the State nurse aide registry<br>rities.<br>ensure that all alleged violations<br>ment, neglect, or abuse,<br>of unknown source and<br>of resident property are reported<br>a administrator of the facility and<br>n accordance with State law<br>ed procedures (including to the<br>certification agency).<br>have evidence that all alleged<br>oughly investigated, and must<br>tential abuse while the | F2                 | 225 |  |      | 5/30/14                    |
| LABORATORY DIRECTOR'S OR PROV  | IDER/SUPPLIER REPRESENTATIVE'S SIGI   | NATURE             |     | TITLE  |      | (X6) DATE<br>05/23/2014    |

## **Electronically Signed**

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.

| CENTER<br>STATEMENT      | RS FOR MEDICARE            | AND HUMAN SERVICES<br>& MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA   | (X2) MU           | LTIPL | F<br>OMB  | ORM /<br><u>3 NO.</u><br>3) DATE | 06/03/2014<br>APPROVED<br>0938-0391 |
|--------------------------|----------------------------|--|-------------------|-------|---|----------------------------------|-------------------------------------|
| AND PLAN C               | OF CORRECTION              | IDENTIFICATION NUMBER:   | A. BUILDING       |       |   | COMF                             |                                     |
|                          |                            | 345325   | B. WING           | ;     |   | C<br>05/14/2014                  |                                     |
| NAME OF I                | PROVIDER OR SUPPLIER       | -  |                   | S     | TREET ADDRESS, CITY, STATE, ZIP CODE  |                                  |                                     |
| CORNER                   | STONE NURSING AN           | ND REHABILITATION CENTER   |                   |       | 11 SUSAN TART ROAD BOX 948  |                                  |                                     |
|                          |                            |  |                   | 0     | OUNN, NC 28334  |                                  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)           | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) |                                  | (X5)<br>COMPLETION<br>DATE          |
| F 005                    |                            |  |                   |       |   |                                  |                                     |
| F 225                    |                            | -  | F :               | 225   |   |                                  |                                     |
|                          |                            | NT is not met as evidenced   |                   |       |   |                                  |                                     |
|                          | by:<br>Based on staff inte | rviews and record review, the  |                   |       | Cornerstone Nursing and Rehabilitati  | ion                              |                                     |
|                          |                            | plete a 24 hour report and a 5   |                   |       | Center acknowledges receipt of the  |                                  |                                     |
|                          |                            | and submit it to the Health  |                   |       | Statement of Deficiencies and propos  | ses                              |                                     |
|                          |                            | gistry and the facility failed to  |                   |       | this Plan of Correction to the extent th  | nat                              |                                     |
|                          |                            | ate an injury of unknown origin  |                   |       | the summary of findings is factually  |                                  |                                     |
|                          | injuries. Findings in      | #1) residents reviewed for   |                   |       | correct and in order to maintain compliance with applicable rules and   |                                  |                                     |
|                          |                            |  |                   |       | provisions of quality of care of residen  | nts                              |                                     |
|                          | Resident #1 was ad         | dmitted on 11/3/09 with  |                   |       | The Plan of Correction is submitted as  |                                  |                                     |
|                          |                            | es cerebral vascular accident  |                   |       | written allegation of compliance.   |                                  |                                     |
|                          |                            | izures, arthritis, diabetes and  |                   |       | Cornerstone Nursing and Rehabilitation  |                                  |                                     |
|                          |                            | annual minimum Data Set  |                   |       | CenterL s response to this Statement  |                                  |                                     |
|                          |                            | ted she had sever cognitive<br>juired extensive assistance   |                   |       | Deficiencies does not denote agreeme<br>with the Statement of Deficiencies nor  |                                  |                                     |
|                          |                            | otal assistance one using a lift,  |                   |       | does it constitute an admission that ar   |                                  |                                     |
|                          |                            | d total assistance for all other   |                   |       | deficiency is accurate. Further,  | ,                                |                                     |
|                          | activities of daily liv    | ing. Resident #1 was care  |                   |       | Cornerstone Nursing and Rehabilitation  | on                               |                                     |
|                          |                            | transfer with the assistance   |                   |       | Center reserves the right to refute any   | y of                             |                                     |
|                          | of one with last revi      | ew date of 4/29/14.  |                   |       | the deficiencies on this Statement of   |                                  |                                     |
|                          | A roviou of an incid       | lent report dated 5/1/14   |                   |       | Deficiencies through Informal Dispute<br>resolution, formal appeal procedure a  |                                  |                                     |
|                          |                            | t1 was noted with abnormal   |                   |       | or any other administrative or legal  | nu/                              |                                     |
|                          |                            | leg by the 11-7 shift staff.   |                   |       | proceeding.   |                                  |                                     |
|                          | There was observe          | d swelling to the right thigh  |                   |       | 1. 24 hour and 5 day report complete  |                                  |                                     |
|                          |                            | in. Witness statements from  |                   |       | by Administrator and faxed to NCHCP   |                                  |                                     |
|                          |                            | indicated resident #1 was  |                   |       | on 5/15/14. The investigation for the in  |                                  |                                     |
|                          | 5                          | ame in at 11:00 PM. She  |                   |       | of unknown origin was initiated by the DON on 5/1/14 and completed on 5/1/  |                                  |                                     |
|                          |                            | I yelling most of the shift and was witness to her yelling. NA   |                   |       | by the Administrator.   | 5/14                             |                                     |
|                          |                            | e that resident #1's right foot  |                   |       | 2. 100% audit was initiated and   |                                  |                                     |
|                          |                            | the right thigh was swollen.   |                   |       | completed on 5-15-14 for last 30 days   | sof                              |                                     |
|                          | The witness statem         | ent from nurse #1 stated   |                   |       | all incidents by DON, ADON, and QI  |                                  |                                     |
|                          |                            | dent #1 was fussy but would  |                   |       | Nurse to ensure any identified injuries   | s of                             |                                     |
|                          |                            | ministered her breathing   |                   |       | unknown origin were thoroughly  | lth                              |                                     |
|                          |                            | icated her with Tylenol for<br>3 3:30 AM, NA#1 reported  |                   |       | investigated and submitted to the Hea<br>Care Personnel Registry. All areas of  |                                  |                                     |
|                          |                            | dent #1's right leg. Nurse #1  |                   |       | concern were addressed by ADON on   |                                  |                                     |
|                          |                            | $10 \text{ m}$ $\pi$ $10 \text{ m}$ $10 $ |                   |       |   | •                                |                                     |

Facility ID: 923073

| ATEMENT                  | OF DEFICIENCIES  | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA   | (X2) MUL            | TIPLE CONSTRUCTION   | OMB NO.<br>(X3) DATE   | E SURVEY                  |
|--------------------------|--|--|---------------------|--|--|---------------------------|
|                          | F CORRECTION   | IDENTIFICATION NUMBER:   |                     | ING  |  | PLETED                    |
|                          |  |  |                     |  | С  |                           |
|                          |  | 345325   | B. WING             |  |  | 14/2014                   |
| NAME OF F                | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP   | CODE   |                           |
| CORNER                   | STONE NURSING AN   | ID REHABILITATION CENTER   |                     | 711 SUSAN TART ROAD BOX 948<br>DUNN, NC 28334  |  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | N SHOULD BE<br>E APPROPRIATE   | (X5)<br>COMPLETIO<br>DATE |
| F 225                    | Continued From pa  | ge 2   | F 2                 | 25   |  |                           |
|                          | assessed her and r<br>both legs and did n  | esident #1 was able to move<br>ot yell. At the end of the shift<br>foot looked more rotated. In  |                     | 5/16/14.   |  |                           |
|                          | a review of the hosy<br>dated 5/1/14, resider<br>right femur fracture<br>to severe pain on 5<br>In an interview on 5<br>director or nursing (<br>investigation of the<br>The investigation w<br>a discussion of the<br>party (RP). Statement<br>that worked with rest<br>5/1/14 and accordined<br>ue to resident #1's<br>history of placing he<br>and a habit of boun<br>when in her chair, the<br>pathological in nature<br>with the outcome of<br>In a telephone inter<br>the nurse practition<br>orders for the x-ray<br>ended up sending N<br>the request of the F<br>was likely pathologi<br>of severe osteoport<br>trauma. | pital emergency room record<br>ent #1 was diagnosed with a<br>and assessed with moderate<br>/1/14.<br>(DON) provided an<br>injury to resident #1 on 5/1/14.<br>as dated 5/2/14 and included<br>injury with the responsible<br>ents were taken from all staff<br>sident #1 on 4/30/14 and<br>ng the DON, it was determined<br>a diagnosis of osteoporosis,<br>er legs over the side of the bed<br>cing her legs up and down |                     | <ol> <li>The Administrator and<br/>Nursing were in-serviced b<br/>clinical director on 5/15/14<br/>thoroughly investigating an<br/>24 hour and 5 day report a<br/>to the Health Care Personn<br/>all injury of unknown origin<br/>Department managers and<br/>in-service initiated 5-15-14<br/>Facilitator and completed of<br/>DON and Administrator reg<br/>guidelines for reporting and<br/>incidents of unknown origin<br/>managers and licensed sta<br/>allowed to work until in-ser<br/>hired department manager<br/>staff will be in-serviced by<br/>upon hire regarding guideli<br/>reporting and investigating<br/>unknown origin. 100% in-ser<br/>CNAL s and therapy staff in<br/>and will be completed on 5<br/>Facilitator regarding observice<br/>reporting injury of unknown<br/>hall nurse. This will include<br/>to bruising, swelling, redne<br/>physical abnormality. CNA<br/>staff will not be allowed to w<br/>in-serviced.</li> </ol> | y the corporate<br>regarding<br>d completing<br>nd submitting<br>nel Registry for<br>s.<br>I licensed staff<br>by the Staff<br>on 5-22-14 by<br>garding<br>d investigating<br>n. Department<br>aff will not be<br>viced. All newly<br>s and licensed<br>Staff Facilitator<br>nes for<br>incidents of<br>service with<br>nitiated 5/23/14<br>/28/14 by Staff<br>ving and<br>n origin to the<br>e but not limited<br>ss, or any<br>L s and therapy<br>work until |                           |
|                          | of unknown origin n  | d he was unaware that injuries<br>leeded to be reported to the<br>ring the 24 hour and 5 working   |                     | QI nurse and RN Supervise<br>Resident Event Tracking L<br>any identified injuries of un<br>were thoroughly investigate<br>submitted to the Health Ca   | og to ensure<br>known origin<br>ed and   |                           |

Facility ID: 923073

| STATEMENT OF DERICENCIES<br>AND PLANT OF CORRECTION       (X1) PROVIDERSUPPLIER/LIL<br>IDENTIFICATION NUMBER:       (X2) MULTIFIE CONSTRUCTION<br>A BUILDING       (X2) DUTTIFIE CONSTRUCTION<br>A BUI   |           |  | I AND HUMAN SERVICES<br>E & MEDICAID SERVICES   |         |   | FORM   | 06/03/2014<br>APPROVED<br>0938-0391 |
|--|-----------|--|---|---------|---|--|-------------------------------------|
| 345325         B. WING         Obj14/2014           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE 2F OD ORFECTION         Obj14/2014           CORNERSTONE NURSING AND REHABILITATION CENTER         STREET ADDRESS, CITY, STATE 2F OD ORFECTION         COMMENT           PREFIX         SUMMARY STATEMENT OF DEFICIENCIES         DIMN, NR. 28334         DUMN, NR. 28334           JTAG         SUMMARY STATEMENT OF DEFICIENCIES         PREFIX         CACH CORRECTION         COMMENT           F 225         Continued From page 3<br>administrator and the DON stated that the<br>fracture that occurred with resident #1 was<br>believed to be pathological in nature based on<br>their investigation but the facility should have<br>submitted the 24 hour and 5 day working report.         F 225         Vere corrected by DON and<br>Administrator immediately. DON or<br>ADON will complete the Accident with<br>Injury Tracking tool for 100% of all injuries x 1<br>month. 50% of all injuries x 1 month and<br>then 10% of all injuries x 1 month. DON or<br>ADON will traview Accident with Injury<br>Tracking tool for 100% of all injuries x 1 month and<br>then 10% of all injuries x 1 month. DON or<br>ADON will conglete and theoroughly<br>investigated for all identified injuries or<br>unknown origins. Administrator will sign<br>off report monthy as an ongoing monitor<br>of incidents.         4. The QL committee will review the<br>results of the audits at weekly 01 meeting<br>for identification or potential issues with<br>follow up taken as deemed appropriate<br>and to determine the continued need and<br>frequency of monitoring.         5/30/14  | STATEMENT | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA   |         |   | (X3) DAT<br>CON  | E SURVEY<br>IPLETED                 |
| NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STREE, ZIP CODE         CORNERSTORE NURSING AND REHABILITATION CENTER       TI SUSAN TART ADDRESS, CITY, STATE, ZIP CODE         (VAL) ID       ISUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCIES DEBY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVIDERS CUTY, STATE, ZIP CODE         F 225       Continued From page 3<br>administrator and the DON stated that the<br>fracture that accurred with resident #1 was<br>believed to be pathological in nature based on<br>their investigation but the facility should have<br>submitted the 24 hour and 5 day working report.       F 225         Q1 nurse, Staff Facilitator or RN<br>Supervisor will complete the Accident with<br>Injury Tracking tool for 100% of all injuries x 1<br>month, 50% of all injuries x 1 month, and<br>then 10% of all injuries x 1 month, and<br>then 10% of all injuries x 1 month, and<br>then 10% of all injuries x 1 month, bON or<br>ADON will initial and date the Accident<br>with Injury Tracking tool for 100% of all injuries x 1<br>month, 50% of all injuries x 1 month, bON or<br>ADON will initial and abte the Accident<br>with Injury Tracking tool for those<br>tresidents reviewed. Any incidents of Injury<br>of Unknown Origins, Atministrator will esport have<br>been complete and thoroughly<br>investigated for all identified injuries or<br>unknown origins an ongoing monitor<br>of incidents.         F 309<br>SS=G       483.25 PROVIDE CARE/SERVICES FOR<br>HIGHEST WELL BEING       F 309  |           |  | 345325  | B. WING |   |  |                                     |
| CORRESTORE JURSING AND REHABILITATION CENTER         DUNN, NC 28334           (X4) ID<br>PREFIX<br>TAG         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST EE MERCEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)         PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY<br>TAG         Comment<br>PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY         Comment<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY         Comment<br>CROSS-REFERENCENT         Comment<br>CROSS-REFERENCENT         Comment<br>CROSS-REFERENCENT         Comment<br>CROSS-REFERENCENT         Comment<br>CROSS-REFERENCENT         Comment<br>CROSS-REFERENCENT         Comment<br>CROSS-REFERENCENT         Comment<br>CROSS-REFERENCENT         Comment<br>CROSS-REFERENCENT         COMMENT         Comment<br>CROSS-REFERENCENT         COMMENT         Comment<br>CROSS-REFERENCENT         COMMENT         COMMENT <t< th=""><th>NAME OF I</th><th>PROVIDER OR SUPPLIER</th><th>1</th><th></th><th>STREET ADDRESS, CITY, STATE, Z</th><th colspan="2"></th></t<>  | NAME OF I | PROVIDER OR SUPPLIER   | 1   |         | STREET ADDRESS, CITY, STATE, Z  |  |                                     |
| PREFIX<br>TAG       (EACH DEFICIENCY ALSO DEFICIENCY MUST REPRECED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX<br>TAG       (EACH CORRECTS ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)         F 225       Continued From page 3<br>administrator and the DON stated that the<br>fracture that occurred with resident #1 was<br>believed to be pathological in nature based on<br>their investigation but the facility should have<br>submitted the 24 hour and 5 day working report.       F 225         OI nurse, Staff Facilitator or RN<br>Supervisor will complete the Accident with<br>Injury Tracking Tool daily for any resident<br>with an injury. Any injury of unknown<br>origin will be reported to the DON and<br>Administrator immediately. DON or<br>ADON will review Accident with Injury<br>Tracking tool for 100% of all injuries x 1<br>month, 50% of all injuries x 1<br>month and the the Accident<br>with Injury Tracking ton portet to the<br>Administrator will ensue<br>swith<br>follow | CORNER    | STONE NURSING AN   | ND REHABILITATION CENTER  |         |   | 8  |                                     |
| administrator and the DON stated that the<br>fracture that occurred with resident #1 was<br>believed to be pathological in nature based on<br>their investigation but the facility should have<br>submitted the 24 hour and 5 day working report.were corrected by DON and<br>Administrator.QI nurse, Staff Facilitator or RN<br>Supervisor will complete the Accident with<br>Injury Tracking Tool daily for any resident<br>with an injury. Any injury of unknown<br>origin will be reported to the DON and<br>Administrator immediately. DON or<br>ADON will review Accident with Injury<br>Tracking tool for 100% of all injuries x 1<br>month, 50% of all injuries x 1 month and<br>then 10% of all injuries x 1 month. DON or<br>ADON will nerse reviewed. Any incidents of Injury<br>of Unknown Origin will be reported to the<br>Administrator immediately. The<br>Administrator will ensure that a 24 hour<br>report and 5 day working report have<br>been complete and thoroughly<br>investigated for all identified injuries or<br>unknown origins. Administrator will sign<br>off report monthy as an ongoing monitor<br>of incidents.F 309<br>Ss=6483.25 PROVIDE CARE/SERVICES FOR<br>HGHEST WELL BEINGF 309Each resident must receive and the facility must<br>provide the necessary care and services to attainF 309  | PRÉFIX    | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL  | PREFIX  | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1   | TION SHOULD BE   | COMPLETION                          |
|  | F 309     | administrator and the<br>fracture that occurre<br>believed to be path<br>their investigation be<br>submitted the 24 he<br>483.25 PROVIDE C<br>HIGHEST WELL B<br>Each resident must | he DON stated that the<br>red with resident #1 was<br>pological in nature based on<br>but the facility should have<br>our and 5 day working report. |         | <ul> <li>were corrected by DON a Administrator.</li> <li>QI nurse, Staff Facilitator Supervisor will complete Injury Tracking Tool daily with an injury. Any injury origin will be reported to Administrator immediate ADON will review Accide Tracking tool for 100% o month, 50% of all injuries then 10% of all injuries an 0 function of potent investigated for all identification of potent follow up taken as deem and to determine the cor frequency of monitoring.</li> </ul> | r or RN<br>the Accident with<br>of any resident<br>of unknown<br>the DON and<br>ly. DON or<br>int with Injury<br>f all injuries x 1<br>s x 1 month and<br>1 month. DON or<br>e the Accident<br>for those<br>incidents of Injury<br>e reported to the<br>ly. The<br>that a 24 hour<br>report have<br>oughly<br>fied injuries or<br>strator will sign<br>ongoing monitor<br>ill review the<br>eekly QI meeting<br>tial issues with<br>ed appropriate |                                     |
|  |           |  |   |         |   |  |                                     |

If continuation sheet Page 4 of 11

| CENTE                    | RS FOR MEDICARE  | AND HUMAN SERVICES   | 1                   |  | FORM<br>OMB NO.  | 06/03/2014<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|---------------------|--|--|-------------------------------------|
| -                        | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED<br>C   |                                     |
|                          |  | 345325   | B. WING             |  |  | _<br>14/2014                        |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZI  |  |                                     |
| CORNER                   | RSTONE NURSING AN  | ND REHABILITATION CENTER   |                     | 711 SUSAN TART ROAD BOX 948<br>DUNN, NC 28334  | 8  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC  | ON SHOULD BE<br>HE APPROPRIATE   | (X5)<br>COMPLETION<br>DATE          |
| F 309                    |  | ge 4<br>osocial well-being, in<br>e comprehensive assessment   | F 30                | 09   |  |                                     |
|                          | by:<br>Based on staff interfacility failed to interest<br>experiencing pain were sident's (resident<br>Findings include:<br>Resident #1 was and<br>cumulative diagnoss<br>with hemiplegia, serest<br>osteoporosis. Here<br>dated 4/3/14 indication<br>impairment and record<br>with bed mobility, to<br>lift, non-ambulatory<br>other activities of date<br>care planned for parts<br>osteoporosis, arthrited<br>A nursing note date<br>read that resident #<br>beginning of third s<br>was concerned about<br>leg. Nurse #1 assets<br>swelling but resider<br>without problem. The<br>grimacing when mode<br>A nursing note date<br>read the third staff of<br>edema to resident and<br>resident and<br>and the sident and<br>and the sident and<br>and the staff of<br>edema to resident and<br>and the sident and<br>and the sident and<br>and the sident and<br>and the staff of<br>edema to resident and<br>and<br>and<br>and<br>and<br>and<br>and<br>and | tis and decreased mobility.<br>d 5/1/14 and timed 8:07 AM,<br>1 was fussy during the<br>hift. Nursing assistant (NA) #1<br>but resident #1's right upper<br>ssed the leg and noted slight<br>at #1 able to move both legs<br>here was no noted increased |                     | Cornerstone Nursing and<br>Center acknowledges red<br>Statement of Deficiencies<br>this Plan of Correction to<br>the summary of findings i<br>correct and in order to ma<br>compliance with applicab<br>provisions of quality of ca<br>The Plan of Correction is<br>written allegation of comp<br>Cornerstone Nursing and<br>CenterL s response to thi<br>Deficiencies does not der<br>with the Statement of Def<br>does it constitute an adm<br>deficiency is accurate. Fu<br>Cornerstone Nursing and<br>Center reserves the right<br>the deficiencies on this S<br>Deficiencies through Infor<br>resolution, formal appeal<br>or any other administrative<br>proceeding.<br>1. Resident #1 assessed<br>MD notified of assessmen<br>received for alternative pa<br>and x-ray of right leg. Pai<br>obtained from facility eme<br>administered by hall nurs<br>Results of x-ray received<br>called to MD by DON; or | ceipt of the<br>s and proposes<br>the extent that<br>s factually<br>aintain<br>le rules and<br>ire of residents.<br>submitted as a<br>bliance.<br>Rehabilitation<br>s Statement of<br>note agreement<br>ficiencies nor<br>ission that any<br>urther,<br>Rehabilitation<br>to refute any of<br>tatement of<br>rmal Dispute<br>procedure and/<br>re or legal<br>5-1-14 by DON;<br>nt and new order<br>ain medication<br>n medication<br>ergency kit and<br>e on 5/1/14.<br>on 5/1/14 and |                                     |

Facility ID: 923073

If continuation sheet Page 5 of 11

|                          | OF DEFICIENCIES   | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTI          | PLE CONSTRUCTION  |   | E SURVEY                  |  |
|--------------------------|---|---|---------------------|---|---|---------------------------|--|
| ND PLAN C                | OF CORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDIN          | G   |   | COMPLETED<br>C            |  |
|                          |   | 245225  |                     |   |   |                           |  |
|                          |   | 345325  | B. WING _           |   |   | 14/2014                   |  |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP COL  | )E  |                           |  |
| CORNEF                   | STONE NURSING AN  | ID REHABILITATION CENTER  |                     | 711 SUSAN TART ROAD BOX 948<br>DUNN, NC 28334   |   |                           |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY)  | HOULD BE  | (X5)<br>COMPLETIO<br>DATE |  |
| F 309                    | Continued From pa   | ae 5  | F 30                | 9   |   |                           |  |
|                          | A review of an incid<br>indicated resident #<br>rotation of the right<br>There was observe<br>and evidence of pa<br>NA #1 indicated resident<br>witnessed her yelling<br>that resident #1's rithe<br>right thigh was<br>statement from nur<br>reported resident #<br>down. She adminis<br>and medicated her<br>beginning of the sh<br>NA#1 reported con<br>leg. Nurse #1 asset<br>able to move both I<br>end of the shift she<br>more rotated.<br>In an interview on 5<br>who worked first sh<br>reported to her that<br>shift and that NA #1 | ch as bruising. There was<br>in. An x-ray was ordered.<br>lent report dated 5/1/14<br>f1 was noted with abnormal<br>leg by the third shift staff.<br>d swelling to the right thigh<br>in. Witness statements from<br>sident #1 was yelling when she<br>M. She recalled resident #1<br>shift and other staff working<br>ng. NA #1 notified the nurse<br>ght foot was turned outward<br>swollen. The witness<br>se #1 stated that NA #1<br>1 was fussy but would quiet<br>tered her breathing treatment<br>with Tylenol for pain at the<br>ift. It was around 3:30 AM,<br>cerns about resident #1 was<br>egs and did not yell. At the<br>stated the right foot looked<br>5/14/14 at 12:10 PM, nurse #2<br>ift on 5/1/14 stated nurse #1<br>resident #1 was fussy on third<br>I thought something was<br>Nurse # 1 and nurse #2 went |                     | obtain orthopedic consult. Ort<br>consult appointment received<br>MD notified of orthopedic con<br>appointment date on 5/1/14 b<br>Order requested by DON and<br>send resident to Emergency F<br>evaluation. Resident #1 respon<br>notified of new orders for alter<br>medication and order to send<br>Emergency Room on 5/1/14 b<br>Resident #1 transferred to Em<br>room 5-1-14.<br>Resident #1 not present at tim<br>2.100% audit of all residents i<br>5/15/14 and completed on 5/2<br>DON, ADON, QI Nurse, and S<br>Facilitator to assess all reside<br>utilizing Pain Assessment Too<br>documentation. The MD was<br>notified of all residents having<br>breakthrough pain and ineffect<br>management by the ADON. P<br>Communication Board was re<br>5/15/14 - 5/22/14 by ADON ar<br>Supervisor. This was to ensur<br>notification was completed by<br>nurse for all residents noted w<br>breakthrough pain, new pain,<br>ineffective pain management.<br>100% audit of all residents pro- | for 5-5-14.<br>sult<br>y DON.<br>ADON to<br>Room for<br>insible party<br>native pain<br>to<br>by hall nurse.<br>hergency<br>he of survey.<br>nitiated<br>(2/14 by<br>Staff<br>nts for pain<br>I for<br>immediately<br>stive pain<br>CC<br>viewed daily<br>hd /or RN<br>the hall<br><i>v</i> ith<br>or |                           |  |
|                          | immediately somet<br>#1's right leg and si<br>went and got the st<br>therapist to assess<br>advised nurse #1 s<br>physician and get a<br>stated she was uns   | #1. Nurse #2 stated she knew<br>hing was wrong with resident<br>he was moaning. Nurse #2<br>aff facilitator and physical<br>resident #1's leg. Nurse #2<br>he needed to notify the<br>in order for an x-ray. Nurse #2<br>ure if nurse #1 notified the RP.<br>e x-ray technician stated  |                     | for past 30 days will be initiate<br>5/23/14 and completed on 5/2<br>Staff Facilitator, QI nurse, Tre<br>Nurse, MDS Coordinator, and<br>for documentation of signs an<br>of pain to ensure all residents<br>with new signs and symptoms<br>and/or ineffective pain manag<br>pain associated with an injury  | 8/14 by<br>atment<br>MDS Nurse<br>d symptoms<br>identified<br>s of pain<br>ement, or  |                           |  |

Facility ID: 923073

| AND HUMAN SERVICES<br>& MEDICAID SERVICES   |   |  | F  | ORM A   | 06/03/2014<br>APPROVED<br>0938-0391  |
|---|---|--|--|---|--|
| (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |  |  | (X3) DATE SURVEY<br>COMPLETED   |  |
| 345325  | B. WING   |  |  | 05/14/2014  |  |
|   |   | ST   | REET ADDRESS, CITY, STATE, ZIP CODE  |   |  |
| D REHABILITATION CENTER   |   |  |  |   |  |
| EMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>C IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG   | ×  |  |   | (X5)<br>COMPLETION<br>DATE   |
| ge 6<br>eriencing pain during x-ray so<br>ke with the assistant director<br>ibout resident #1 pain. Nurse<br>vas positive for a right femur<br>ified the RP and physician.<br>ed an orthopedic consult and<br>n. Nurse #2 stated she was<br>pointment with an orthopedic<br>wing Monday but due to<br>ne RP requested resident #1<br>spital for an evaluation. She<br>ered the ordered pain<br>nt #1 at 12:00 PM prior to her<br>the hospital.<br>14/14 at 12:20 PM, nurse #3<br>slept most of the day on<br>/14. She recalled the NA #3<br>ed at the early part of second<br>e end of the shift she noted<br>Nurse #3 stated she did not<br>ent #1 because she had<br>e #1.<br>14/14 at 12:40 PM, NA #2<br>vith resident #1 on first shift<br>gotten resident #1 up in her<br>resident #1's care guide<br>lift with one person<br>nibited her usual behavior of<br>sed no yelling or evidence of | F 3   | 09   | and MD/RP notified.<br>100% in-service initiated by Staff<br>Facilitator on 5/16/14 and will be<br>completed on 5/28/14 by Staff Facilita<br>and DON with all CNAL s and therapy<br>staff regarding reporting to hall nurse,<br>signs and symptoms of pain. CNAL s<br>therapy staff will not be allowed to wo<br>until in-serviced is received. All newly<br>hired CNAL s and therapy staff will be<br>in-serviced by Staff Facilitator upon hi<br>orientation on reporting to hall nurse s<br>and symptoms of pain.<br>100% in-service initiated by Staff<br>Facilitator 5/16/14 and completed 5/2.<br>by Staff Facilitator and DON with Lice<br>Nurses regarding assessment of pain<br>include pain associated with an injury<br>notification to MD of new signs and<br>symptoms of pain and/or ineffective p<br>management. Licensed nurses will no<br>allowed to work until in-serviced is<br>received. All newly hired Licensed Nu<br>will be in-serviced upon hire in orienta<br>by Staff Facilitator regarding assessm<br>of pain to include pain associated with<br>injury and notification to MD of new si<br>and symptoms of pain and/or ineffect<br>pain management.<br>On 5/19/14 ADON, Staff Facilitator, C<br>nurse, Treatment Nurse, MDS<br>Coordinator, and MDS Nurse were<br>in-serviced by DON regarding monito<br>Progress Notes, Pain Alerts, and Beh<br>documentation utilizing QI Tool for<br>Monitoring Progress Notes for Acute<br>Changes to Include Pain and QI Tool | ator<br>y<br>and<br>ork<br>y<br>e<br>nire in<br>signs<br>22/14<br>ensed<br>n to<br>y and<br>bain<br>ot be<br>urses<br>ation<br>nent<br>h an<br>igns<br>tive<br>QI<br>pavior   |  |
|   | <u>A MEDICAID SERVICES</u> <u>X1) PROVIDER/SUPPLIER/CLIA</u> <u>IDENTIFICATION NUMBER:</u> <u>345325</u> <b>D REHABILITATION CENTER</b> EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)<br>He 6 eriencing pain during x-ray so ke with the assistant director bout resident #1 pain. Nurse //as positive for a right femur fied the RP and physician. ed an orthopedic consult and n. Nurse #2 stated she was ointment with an orthopedic ving Monday but due to the RP requested resident #1 pital for an evaluation. She pred the ordered pain nt #1 at 12:00 PM prior to her the hospital.<br>14/14 at 12:20 PM, nurse #3 slept most of the day on /14. She recalled the NA #3 d at the early part of second e end of the shift she noted Nurse #3 stated she did not ent #1 because she had #1.<br>14/14 at 12:40 PM, NA #2 rith resident #1 on first shift gotten resident #1 up in her fore lunch and when she left #1 was still sitting up in her esident #1's care guide lift with one person nibited her usual behavior of sed no yelling or evidence of | AMEDICAID SERVICES         X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       (X2) MULT<br>A. BUILDI         345325       B. WING         OREHABILITATION CENTER       ID<br>PREFID<br>TAG         CREHABILITATION CENTER       ID<br>PREFID<br>TAG         EMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>CIDENTIFYING INFORMATION)       ID<br>PREFID<br>TAG         ee 6       F 3         eriencing pain during x-ray so<br>ke with the assistant director<br>bout resident #1 pain. Nurse<br>vas positive for a right femur<br>ified the RP and physician.<br>ed an orthopedic consult and<br>h. Nurse #2 stated she was<br>ointment with an orthopedic<br>ving Monday but due to<br>he RP requested resident #1<br>pital for an evaluation. She<br>red the ordered pain<br>nt #1 at 12:00 PM prior to her<br>the hospital.         14/14 at 12:20 PM, nurse #3<br>slept most of the day on<br>/14. She recalled the NA #3<br>d at the early part of second<br>e end of the shift she noted<br>Nurse #3 stated she did not<br>ent #1 because she had<br>#1.         14/14 at 12:40 PM, NA #2<br>ith resident #1 on first shift<br>gotten resident #1 up in her<br>esident #1's care guide<br>lift with one person<br>hibited her usual behavior of<br>sed no yelling or evidence of<br>sed no yelling or evidence of<br>sed no yelling or evidence of | & MEDICAID SERVICES         X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       (X2) MULTIPLI<br>A. BUILDING         345325       B. WING         345325       B. WING         0       T         CREHABILITATION CENTER       ID<br>PREFIX<br>TAG         EMENT OF DEFICIENCIES<br>WUST BE PRECEDED BY FULL<br>CIDENTIFYING INFORMATION)       ID<br>PREFIX<br>TAG         ee 6       F 309         eriencing pain during x-ray so<br>ce with the assistant director<br>boot resident #1 pain. Nurse<br>vas positive for a right femur<br>ified the RP and physician.<br>ed an orthopedic consult and<br>h. Nurse #2 stated she was<br>ointment with an orthopedic<br>ving Monday but due to<br>the RP requested resident #1<br>pital for an evaluation. She<br>ered the ordered pain<br>int #1 at 12:00 PM prior to her<br>the hospital.         14/14 at 12:20 PM, nurse #3<br>slept most of the day on<br>/14. She recalled the NA #3<br>d at the early part of second<br>e end of the shift she noted<br>Nurse #3 stated she did not<br>ent #1 because she had<br>#1.         14/14 at 12:40 PM, NA #2<br>rith resident #1 on first shift<br>g otten resident #1 up in her<br>esident #1's care guide<br>lift with one person<br>ibibited her usual behavior of<br>sed no yelling or evidence of         iew on 5/14/14 at 12:45 PM,<br>ard resident #1 yelling when<br>er shift at 11:00 PM on   | NND HUMAN SERVICES       OM         & MEDICAID SERVICES       OM         & MEDICAID SERVICES       OM         x1 PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       (2) MULTIPLE CONSTRUCTION<br>A BUILDING       (2)         345325       B. WING       STREET ADDRESS, CITY, STATE, ZIP CODE<br>711 SUSAN TART ROAD BOX 948<br>DUNN, NC 28334       (2)         DENEMABILITATION CENTER       ID<br>PREFIX<br>TAG       PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCE) TO THE APPOPRIA<br>DEFICIENCY)       (2)         te 6       F 309       assessed by the hall nurses, interver<br>and MD/RP notified.       (2)         as positive for a right femur<br>fied the RP and physician.<br>ad an orthopedic consult and<br>n. Nurse #2 stated she was<br>ointment with an orthopedic<br>wing Monday but due to<br>e RP requested resident #1<br>pital for an evaluation. She<br>red the ordered pain<br>mt #1 at 12:00 PM, nurse #3<br>slept most of the day on<br>14/14 at 12:40 PM, NA#2<br>tith resident #1 on first shift<br>of at the early part of second<br>e and of the shift she noted<br>#11 was still stifting up in her<br>esident #1 on gerson<br>include pain associated with an injury<br>notification to MD of new signs and<br>symptoms of pain and/or ineffective p<br>management. Licensed nurses will<br>nallowed to work until in-serviced by Staff<br>Facilitator 5/16/14 and completed 5/2<br>by Staff Facilitator and DON with Lic<br>Nurse #3 stated she did not<br>ent #1 because she had<br>#11.       Nurse #3<br>slept most of the day on<br>14/14 at 12:40 PM, NA#2<br>tith resident #1 up in her<br>softer seident #1 up in her<br>softer seident #1 up in her<br>esident #1's care guide<br>lift with one person<br>to the usual behavior of<br>sed no yelling or evidence of<br>early restrict the origing monitis<br>to the h | NND HUMAN SERVICES       FORM / C         MEDICAID SERVICES       OMB NO.         X) PROVIDERSUPPLIERCLA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE         345325       B. WING       C         345325       B. WING       C         D REHABILITATION CENTER       DID       STREET ADDRESS, CITY, STATE, ZIP CODE       711 SUSAN TART ROAD BOX 948         DUNN, NC 28334       DUNN, NC 28334       DUNN, NC 28334         DUNST BE PRECEDED BY FULL       PROVIDERS PLAY OF CORRECTION       C         COME TAGE STATE TADDRESS, CITY, STATE, ZIP CODE       711 SUSAN TART ROAD BOX 948       DUNN, NC 28334         DUNN NC 28334       DUNN, NC 28334       DUNN, NC 28334         UST BE PRECEDED BY FULL       PROVIDERS PLAY OF CORRECTION       assessed by the hall nurses, intervened, and MD/RP notified.         NUTS BY PRECEDED BY FULL       F 309       assessed by the hall nurses, intervened, and MD/RP notified.         NUTS BY PRECENDER STATE ADDRESS, CITY, STATE, ZIP CODE       F 302       assessed by the hall nurses, intervened, and MD/RP notified.         NUTS BY PRECENDER STATE ADDRESS, CITY, STATE, ZIP CODE       F 303       assessed by the hall nurses, intervened, and MD/R P notified.         NUTS BY PRECENDER STATE ADDRESS, CITY, STATE, ZIP CODE       F 304       assessed by the hall nurse, intervened, in the any thy thif f acilitator         NUTS B |

Facility ID: 923073

| TATEMENT                 | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    | TIPLE CONSTRUCTION   |   | E SURVEY<br>PLETED         |  |
|--------------------------|---|--|--------------------|--|---|----------------------------|--|
|                          | F CORRECTION  | IDENTIFICATION NOMBER.   | A. BUILD           | NG   |   | C                          |  |
|                          |   | 345325   | B. WING            |  |   | 05/14/2014                 |  |
| NAME OF                  | PROVIDER OR SUPPLIER  | •  |                    | STREET ADDRESS, CITY, STATE, ZIP C   | CODE  |                            |  |
| CORNEF                   | RSTONE NURSING AN   | ND REHABILITATION CENTER   |                    | 711 SUSAN TART ROAD BOX 948<br>DUNN, NC 28334  |   |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF CO<br>X (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)   | N SHOULD BE   | (X5)<br>COMPLETION<br>DATE |  |
| F 309                    | Continued From pa   | ge 7   | F 3                | 09   |   |                            |  |
|                          | give resident #1 sor<br>continued with mak<br>NA #1 stated it was<br>resident #1 again b<br>her peers discussed<br>with resident #1 bed<br>yell. Na #1 stated s<br>pulled the cover bad<br>#1 was wet and she<br>swollen. NA #1 stat<br>but nurse #1 did no<br>that time. NA #1 stat<br>AM, she and nurse<br>resident #1's right le<br>normal but did appet<br>thigh. At the end of<br>resident #1 was stil<br>AM.<br>In an interview on 5<br>stated resident #1 r<br>her normal behavio<br>recalled the staff fa<br>#1's leg did not look<br>in pain. She recalle<br>and the x-ray techn<br>the leg was likely fra<br>to move her leg. Th<br>the physician's offic<br>and spoke with the<br>resident #1 pain an<br>pain medication and<br>the hospital since a<br>unlikely till the follow<br>In a telephone inter | mething for pain and she<br>sing her first rounds of the shift.<br>about 10 minutes later that<br>egan yelling and she noted<br>d that something was wrong<br>cause it was not like her to<br>she went into the room and<br>ck to check to see if resident<br>e noticed her thigh was<br>ed she went and told nurse #1<br>it go and assess resident #1 at<br>ated at around 3:00 AM or 4:00<br>#1 went together to look at<br>eg. Nurse #1 stated it looked<br>ear slightly swollen to her right<br>her shift, NA # 1 noted<br>I yelling when she left at 7:00<br>6/14/14 at 1:40 PM, the ADON<br>never yelled or screamed and<br>or was verbal gibberish. She<br>cilitator telling her that resident<br>k right but she did not appear<br>d getting an order for an x-ray<br>ician coming to her and stated<br>actured and he was not going<br>he ADON stated she was at<br>ce picking up some paperwork<br>nurse practitioner about<br>d got an order for a narcotic<br>d orders to send resident #1 to<br>in orthopedic consult was |                    | <ul> <li>ensure new signs and sympand/or ineffective pain manassessed by the hall nurse notified.</li> <li>3. All resident progress note Behavior Documentation, a reports will be monitored by Facilitator, QI nurse, Treatm MDS Coordinator, and MDS utilizing Pain Audit Tool to e residents identified with new symptoms of pain and/or in management, or pain associnjury has been assessed be nurses, intervened, and MD All identified areas of concected by DON and ADC Pain Audit Tool will be comp x 4 weeks, 3 x week x 4 we weekly x 4 weeks by QI Nu Facilitator, Treatment Nurse Coordinator, and MDS Nurse Pain Audit Tool will be monic completion by Administrato ADON 2 x week x 4 weeks, 4 weeks, then monthly x 1 in QI Tool for New Signs of Pain factor of potential issup taken as deemed approdetermine the continued near frequency of monitoring.</li> </ul> | agement is<br>and MD/RP<br>es, Pain Alerts,<br>nd incident<br>/ Staff<br>nent Nurse,<br>S Nurse<br>ensure all<br>w signs and<br>effective pain<br>ciated with an<br>y the hall<br>D/RP notified.<br>ern will be<br>DN.<br>bleted 5 x week<br>eeks, then<br>rse, Staff<br>e, MDS<br>se.<br>tored for<br>r, DON, or<br>, then weekly x<br>month utilizing<br>ain and/or<br>ent. |                            |  |

|  |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                     |     |  | FORM                          | APPROVED<br>0938-0391 |  |
|--|---|---|---------------------|-----|--|-------------------------------|-----------------------|--|
| STATEMENT OF   | F DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA   | • •                 |     | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                       |  |
| AND PLAN OF C  | JORRECTION  | IDENTIFICATION NUMBER:  | A. BUILDI           | ING |  |                               | C                     |  |
|  |   | 345325  | B. WING             | -   |  |                               |                       |  |
| NAME OF PRO  | OVIDER OR SUPPLIER  |   |                     |     | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                       |  |
| CORNERS  | CORNERSTONE NURSING AND REHABILITATION CENTER   |   |                     |     | 11 SUSAN TART ROAD BOX 948<br>DUNN, NC 28334   |                               |                       |  |
| (X4) ID<br>PREFIX<br>TAG   |   |   | ID<br>PREFIX<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ULD BE COMPLÉTI               |                       |  |
| th<br>al<br>N<br>So<br>th<br>e<br>W<br>P<br>W<br>N<br>D<br>In<br>fare<br>plas<br>#<br>th<br>o<br>In<br>st<br>5,<br>in<br>cib<br>hid<br>ib<br>a<br>r<br>In<br>N<br>M<br>S<br>So<br>So | IA #3 recalled reside<br>o she rolled reside<br>the lift pad and char<br>esident #1 did not of<br>the care was prove<br>M, she heard reside<br>the rough the room for<br>to touch her or remody.<br>The an interview on 55<br>acilitator stated nur<br>esident #1's right let<br>hysical therapist (F<br>esident #1. The state<br>of the state of the room for<br>the state of the room for<br>the state of the state<br>of the bed. She was<br>rying and grimacin<br>oney prominence to<br>is and thought resi-<br>is located or fractur<br>eing externally rota<br>n x-ray of the entim-<br>ule out a femur fract<br>of the recalled discus<br>omething wrong w | Founds on her at<br>PM and again at 10:30 PM.<br>dent #1 being wet at 10:30 PM<br>ent #1 onto her left side using<br>nged her brief. NA #3 stated<br>exhibit any overt signs of pain<br>vided. It was at around 10:50<br>dent #1 yelling. She stated she<br>to check resident #1 but did<br>nove her covers to see her<br>7/14/14 at 2:20 PM, the staff<br>rse #2 asked her to assess<br>eg. She recalled asking the<br>PT) to go with her to assess<br>aff facilitator stated resident<br>urned outward and her right<br>out resident #1 was not yelling<br>7/14/14 at 2:30 PM, the PT<br>ent of resident #1's right leg on<br>ed resident #1 thrashing about<br>a not screaming but she was<br>ig. The PT stated she felt a<br>to the right lateral side of the<br>ident #1 's right leg was either<br>red. The PT noted the leg<br>ated as well. She suggested<br>re leg and not just the hip to | F 3                 | 09  |  |                               |                       |  |

|                          |  | AND HUMAN SERVICES  |                     |      |   | FORM                                  | APPROVED                   |
|--------------------------|--|---|---------------------|------|---|---------------------------------------|----------------------------|
|                          |  | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULT           | TIPL | E CONSTRUCTION  | OMB NO. 0938-0391<br>(X3) DATE SURVEY |                            |
|                          | F CORRECTION   | IDENTIFICATION NUMBER:  | • •                 |      |   | СОМ                                   | PLETED                     |
|                          |  | 345325  | B. WING _           |      |   |                                       | C<br>14/2014               |
| NAME OF F                | PROVIDER OR SUPPLIER   |   | · [                 | S    | TREET ADDRESS, CITY, STATE, ZIP CODE  | •                                     |                            |
| CORNER                   | STONE NURSING AN   | ID REHABILITATION CENTER  |                     |      | 11 SUSAN TART ROAD BOX 948<br>UNN, NC 28334   |                                       |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | ¢    | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                                  | (X5)<br>COMPLETION<br>DATE |
| F 309                    | Continued From pa  | ge 9  | F 30                | 09   |   |                                       |                            |
|                          | In a telephone inter<br>the nurse practition<br>speaking to the ADO<br>resident #1 into to s<br>she gave an order f<br>decided to send res<br>evaluation. The NP<br>expectation that any<br>expressing pain, the<br>and send the reside<br>immediately.<br>In a telephone inter<br>NA #5 stated reside<br>legs over the side of<br>babble when she w<br>she was working or<br>not hear resident #1<br>hearing her peers d<br>resident #1 was yel<br>In a telephone inter<br>nurse #1 stated she<br>her midway through<br>resident #1 was fus<br>Tylenol and later in<br>look at resident #1's<br>resident #1 was mod<br>look more turned of<br>around 6:45 AM. T<br>right leg. Nurse #1 s<br>resident #1 yelling of<br>In a review of the her<br>record, resident #1 | view on 5/14/14 at 2:50 PM,<br>er (NP) stated she recalled<br>ON about not being able to get<br>see an orthopedic doctor and<br>for a pain medication. It was<br>sident #1 to the hospital for<br>stated it would be her<br>y resident with an acute injury<br>e facility contact the physician<br>ent out to the hospital<br>view on 5/14/14 at 3:00 PM,<br>ent #1 was known to throw her<br>of the bed and she would<br>as cold or wet. NA #5 stated<br>a 200 hall on 5/1/14 and did<br>1 yelling but she did recall<br>liscussing concerns about why<br>ling.<br>view on 5/14/14 at 3:20 PM,<br>e recalled NA #1 approaching<br>a third shift stating that<br>sy. She stated she gave her<br>the shift NA #1 asked her to<br>a right leg. Nurse #1 stated<br>oving her legs but the right leg<br>utward so she notified the NP<br>he NP ordered an x-ray of<br>stated she did not hear<br>or screaming on her shift. |                     |      |   |                                       |                            |

If continuation sheet Page 10 of 11

|                          |  | AND HUMAN SERVICES  |                   |     |  | FORM                               | 06/03/2014<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|-------------------|-----|--|------------------------------------|-------------------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED<br>C |                                     |
|                          |  | 345325  | B. WING           | ;   |  |                                    | _<br>14/2014                        |
| NAME OF I                | NAME OF PROVIDER OR SUPPLIER               |   |                   |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |                                    |                                     |
| CORNER                   | STONE NURSING AN                           | ND REHABILITATION CENTER  |                   |     | 711 SUSAN TART ROAD BOX 948<br>DUNN, NC 28334  |                                    |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                           | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | IX  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                                 | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | administrator and the expectation that the | age 10<br>5/14/14 at 4:00 PM, the<br>he DON stated it was their<br>e staff call the physician and<br>sident exhibits evidence of pain |                   | 309 |  |                                    |                                     |

Facility ID: 923073