DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				-	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	` ´con	TE SURVEY MPLETED
		345325	B. WING				C / 30/2014
NAME OF F	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
CORNER	STONE NURSING AN	ND REHABILITATION CENTER			JSAN TART ROAD BOX 948 I, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT		F 0(00			
F 157 SS=J	(DHSR), Nursing H Certification Section investigation survey team went back to gather additional im decision that the fa- of care at the imme extended survey wa an exit conference 06/30/14. The Imm 05/31/14 and was r 483.10(b)(11) NOT (INJURY/DECLINE A facility must imme consult with the res known, notify the re- or an interested fan accident involving t injury and has the p intervention; a signi physical, mental, or deterioration in hea status in either life f clinical complication significantly (i.e., a existing form of treat consequences, or t treatment); or a dec the resident from th §483.12(a). The facility must als and, if known, the r or interested family		F 1	57			7/22/14
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURF		TITLE		(X6) DATE
	ically Signed						07/17/2014

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.

AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/25/2014 APPROVED 0938-0391	
X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C		
345325	B. WING			06/30/2014		
		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
D REHABILITATION CENTER	711 SUSAN TART ROAD BOX 948 DUNN, NC 28334					
EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIZ TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
te 1 5(e)(2); or a change in Federal or State law or fied in paragraph (b)(1) of ord and periodically update or number of the resident's or interested family member. T is not met as evidenced view, staff and physician y failed to immediately notify gnificant change in a for 1 (Resident #1) of 3 The resident had episodes of g, low blood pressure, and tion. The resident was spital. The Immediate 5/31/14. The administrator nmediate Jeopardy on The Immediate Jeopardy was at 8:59 pm when the facility ble credible allegation of ility will remain out of be and severity of no actual ial for more than minimal rediate Jeopardy (D). The bocess of full implementation eir corrective action. d: mitted to the facility on diagnoses which included hypertension. The nurses hrough 5/30/14 documented rt and oriented.	F1	157	Center acknowledges receipt of the State Deficiencies and proposes this Pla Correction to the extent that the summary of fi is factually correct and in order to ma compliance with applicable rules an provisions of quality of care of residents. The Correction is submitted as a writter allegation of compliance. Cornerstone Nursing and Rehabilit Center response to this Statement of Defic does not denote agreement with the Stat of Deficiencies nor does it constitute a admission that any deficiency is accurate. Fur Cornerstone Nursing and Rehabilit Center	ment of n of indings intain nd Plan of n ation ciencies tement an ther, ation		
	<u>A MEDICAID SERVICES</u> <u>X1) PROVIDER/SUPPLIER/CLIA</u> <u>IDENTIFICATION NUMBER:</u> <u>345325</u> D REHABILITATION CENTER EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) de 1 (e)(2); or a change in Federal or State law or fied in paragraph (b)(1) of ord and periodically update ne number of the resident's or interested family member. T is not met as evidenced view, staff and physician y failed to immediately notify gnificant change in a or 1 (Resident #1) of 3 The resident had episodes of g, low blood pressure, and tion. The resident was spital. The Immediate 5/31/14. The administrator nmediate Jeopardy on The Immediate Jeopardy on The Immediate Jeopardy was at 8:59 pm when the facility ble credible allegation of ility will remain out of be and severity of no actual ial for more than minimal rediate Jeopardy (D). The bress of full implementation eir corrective action. d: mitted to the facility on diagnoses which included hypertension. The nurses	A MEDICAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 345325 B. WING 345325 B. WING O REHABILITATION CENTER ID WIST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) ID PREFINATION e 1 F 1 fe(e)(2); or a change in Federal or State law or fied in paragraph (b)(1) of F 1 ord and periodically update ne number of the resident's or interested family member. F 1 T is not met as evidenced view, staff and physician y failed to immediately notify prificant change in a or 1 (Resident #1) of 3 The resident had episodes of g, low blood pressure, and tion. The resident was spital. The Immediate 5/31/14. The administrator namediate Jeopardy on The Immediate Jeopardy was at 8:59 pm when the facility ble credible allegation of ility will remain out of oe and severity of no actual ial for more than minimal ediate Jeopardy (D). The poess of full implementation eir corrective action. d: mitted to the facility on diagnoses which included nypertension. The nurses prough 5/30/14 documented t and oriented.	AMEDICAID SERVICES (X2) MULTIPL X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL IDENTIFICATION NUMBER: B. WING 345325 B. WING CREHABILITATION CENTER ID EMENT OF DEFICIENCIES PREFIX MUST BE PRECEDED BY FULL PREFIX C IDENTIFYING INFORMATION) PREFIX ref Federal or State law or ie (a) (2); or a change in Federal or State law or Federal or State law or Federal or State law or or interested family member. T T is not met as evidenced View, staff and physician y failed to immediately notify pnificant change in a or 1 (Resident #1) of 3 The resident was The resident had episodes of Nublood pressure, and tion. The resident was spital. The Immediate 5/31/14. The administrator So at 8:59 pm when the facility ble credible allegation of Millipwill remain out of be and severity of no actual ial for more than minimal rediate Jeopardy (D). The Decess of full implementation eir corrective action. d: mitted to the facility on diagnoses	NND HUMAN SERVICES O MEDICAID SERVICES O MEDICAID SERVICES O ND HUMAN SERVICES O ND RUDERSUPPLIERCIA (2) MULTIPLE CONSTRUCTION A BUILDING	ND HUMAN SERVICES OMB NO. XI PROVIDER/SUPPLER/CLA IDENTIFICATION NUMBER (2) MULTIPLE CONSTRUCTION A BUILDING (2) MULTIPLE CONSTRUCTION A BUILDING CONSTRUCTION (2) STON (2) MULTIPLE CONSTRUCTION (2) STON (2) MULTIPLE CONSTRUCTION (2) STON (2) MULTIPLE CONSTRUCTION (2) STON (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONS	

Facility ID: 923073

		AND HUMAN SERVICES			PRINTED: 07/25/20 FORM APPROVE OMB NO. 0938-03
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345325	B. WING		C 06/30/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
CORNER	STONE NURSING AN	ND REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTIC
F 157	Continued From pa	ge 2	F 15	7	
	Review of the nurse 1:21pm by Nurse # was alert and orient documented "reside has not eaten since administered for na nurse's note further been nauseated an lunch. Call light corr On 6/13/14 at 12:09 NA #2 worked on th and 5/31/14 and sh the resident. NA #2 she did not feel wel morning, she stated nauseated. NA #2 she did not feel wel morning, she stated she informed family members co continued complain further stated "(Re	es note dated 5/31/14 at 1 documented the resident ted. The same note ent has been sick this shift and breakfast, Zofran usea and vomiting." The documented "Resident has d throwing up since before		 deficiencies on this Statement of Deficiencies Informal Dispute Resolution, form appeal procedure and/or any other admit or legal proceeding. Resident #1 is no longer at the fat 100% audit of all resident s daily progress notes in the last 30 days initiated by the MDS Coordinator, nurse, QI nurse, Treatment nurse Staff Facilitator on 6/19/14, 6/20/7 6/21/14, 6/22/14, 6/23/14, 6/24/1 6/29/14, and completed by 6/30/1 ensure residents who have had a change in condition to include but limited to change in mental alerth orientation, increased weakness fatigue, change in abilities to feed or groom self, change in sitting bat transfer, or walking ability, changa appetite, change in ability to chew food, difficulty with breathing, decoxygen saturation, complaints of dizziness, change in bowel elimin habits, complaints of nausea and vomiting, and falls were assessed include vital signs and 02 sats, appropriate interventions placed, Attending Physician notification. resident was assessed and Atten Physician notified on 6/19/14. The 	nal nistrative cility. s was MDs e and 14, 4, 4, 4 to n acute t not ess and or l, bathe, alance, e in v/swallow reased ation d to and sible ge. One e The ding

Facility ID: 923073

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		E CONSTRUCTION	MB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				· · /	PLETED
			-				C
		345325	B. WING _			06/3	30/2014
IAME OF	PROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
ORNE	RSTONE NURSING A	ND REHABILITATION CENTER			11 SUSAN TART ROAD BOX 948 JUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 157	Continued From pa	age 3	F 15	57			
F 157	Review of the writted documented in par lunchtime, I was ca When I entered the cleaning up some of gown. The vomitus food resident was of During an interview OTA (Occupational the resident completed 5/31/14. She furtheter resident from 12:19 approximately. She complained of feelites she scooted the rest for her lunch meal. sick and throwing up resident was puffy She further stated The OTA further stated The OTA further stated the resident and the any kind. She furtheter resident because as Nurse #1 informed physician and poss the hospital. The O 30 minutes later to could not understate been sent out to the The OT (Occupation Note dated 5/31/14 dependent with beap positioning in bed for the state of	en statement by RN supervisor t "On May 31st around alled to (Resident #1's) room. e room, (Nurse #1) was vomitus off the resident's appeared to be some of the eating." o on 6/13/14 at 12:58 pm, the Therapist Assistant) #1 stated ained of not feeling well on er stated she worked with the 5 pm to 12:30 pm e stated the resident ng tired and sick. She stated sident up in bed to prepare her She stated the resident was up. She further indicated the and glossy from the edema. she went and got Nurse #1. ated after Nurse #1 assessed e nurse withheld treatment of er stated withholding of or her not to work with the she was too sick. She stated her that she was calling the sibly sending the resident out to OTA stated she went back about check on Resident #1 and nd why the resident had not	F 15	57	Attending Physician and Responsite Party notification will be documented the progress notes by the hall nurse 100% head to toe assessment was completed by ADON, Staff Facilitat nurse, MDS Coordinator, MDS nurse Treatment nurse on 6/30/14 on all residents for any acute change in condition to include but not limited change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, or groom self, change is sitting bala transfer, or walking ability, change appetite, change in ability to chew/s food, difficulty with breathing, decre oxygen saturation, complaints of dizziness, change in bowel eliminat habits, complaints of nausea and vomiting, and falls. The Attending Physician and Responsible Party w notified and appropriate interventio initiated with all identified changes condition to include but not limited change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, or groom self, change in sitting bala transfer, or walk, change in appetite change in ability to chew/swallow for difficulty with breathing, decreased saturation, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting falls. This assessment, Attending Physician, Responsible Party notific and appropriate interventions were	ed in e. or, QI se and to bathe, ance, in swallow eased tion /as ns in to bathe, ance, e, oxygen , and cations	

Facility ID: 923073

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		C	MB NO.	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	Сом	E SURVEY PLETED
		345325	B. WING		06/3	C 30/2014
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CORNE	STONE NURSING AN	ND REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 157	Continued From pa	ige 4	F 15	7		
	room. After nurse a treatment of any kin physician and poss to vitals related to C On 6/13/14 at 11:17 NA #1 worked the 7 was not responsible shift. NA#1 was re the 3 pm -11 pm sh Resident #1 compla beginning of the sh #1 vomited during h stated Resident #1 self. The NA further tired, sleepy and we taken the resident's the vomiting episod low. The NA stated blood pressure rea #2 took the vital sig further stated she w 3 pm she was assig stated when she we shortly after 3 pm, 1 and her mouth was NA #3 to come and resident's color was resident was not ta further stated she w reported the finding Nurse #1 told her s some medication e Nurse#1 that the re well. She stated aft stopped by the Med	A called nurse (Nurse #1) to assessment, nursing withheld and and reports calling ible out to hospital secondary CHF (congestive heart failure)." 7 am, NA #1 was interviewed. 7-3 shift on 5/31/14 but she e for this resident during this sponsible for this resident on off on 5/31/14. NA #1 stated ained of not feeling well at the ift. She further stated Resident her breakfast meal. NA #1 was not acting her normal r stated "She was out of it, eak." NA #1 stated NA #2 had s vital signs that morning after le and the blood pressure was she remembered seeing the ding on the machine after NA yorked a double shift and after gned to Resident #1. NA #1 vorked a double shift and after gned to Resident #1. She ent in to check on Resident #1 Resident #1's skin was yellow open. She stated she asked verify with her that the s yellow. She stated the lking straight to them. NA #2 vent to the nurse's station and gs to Nurse #1. She stated he had given the resident arlier. The NA stated she told esident was still not feeling er she left Nurse #1, she dication Aide on duty and he resident was not feeling well polor.		100% of licensed nurses were in-s by the Staff Facilitator and complet 6/30/14 in regards to notification to physician by telephone when an a change in condition occurs, includ changes in cognitive status, behave changes to include fluids, immune response, normal body system functioning, panic laboratory value decreased oxygen saturation and immediate application of oxygen if are low, resident s condition warr based upon nurse s assessment are unable to reach Attending Phy you may call On-call for physician; are unable to reach attending or o physician, you may call the facility Medical Director. Notification of t physician of these types of acute o in a resident s condition by fax is acceptable. All newly hired license nurses will be inserviced by the St Facilitator during orientation notific physician by telephone when an a changes in condition occur, includ changes in cognitive status, behave changes to include fluids, immune response, normal body system functioning, Panic laboratory value resident s condition warrants bas nurse s assessment; If you are u to reach Attending Physician, you On-call for physician; If you are un reach attending or on-call physicia may call the facility Medical Dire notification of the physician of thes of changes in a resident s conditi fax is not acceptable.	ted on o the cute ing vior, oral a system es, f o2 sats ants ; If you sician, lf you sician, lf you n-call s he changes not ed aff cation to cute ing vior, oral aff system es, ed upon inable may call able to in, you ector, se types	

Facility ID: 923073

		AND HUMAN SERVICES			F	FORM /	07/25/2014 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE SURVEY COMPLETED C			
		345325	B. WING _				, 30/2014		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
CORNER	RSTONE NURSING AN	ID REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 157	Continued From pa	ge 5	F 1	57					
	(Resident #1) was y having diarrhea. As #1) was still feeling around 2:45pm, wh (Resident #1) beca She raised her voic send her out for voi walked away. Aroun looking yellow. I told she agreed with me and asked her to lo stated 'I'm sending During an interview Medication Aide #1 stated she was not condition by the off- aide further stated s see the resident aft the hall at 3pm. She later in the shift by I resident being sick Review of the nurse 5:31pm by RN supe and CNA asked wri resident (rsdt). Res present and stated responding normall and swollen. Writer hard to arouse, coo respirations of 28. (Foley with tea color writer that resident PT (physical therap	statement by NA#1 "On Saturday, 5/31/14 very sick, sick vomiting and the day went on, (Resident bad. I asked (Nurse #1) at would we do about use she was still doing bad. e at me and stated "I can't miting and diarrhea. I then nd (time unclear) she was d (NA #3) to look at her and e. I then went to RN supervisor ok at (Resident #1) and she her out, I've called EMS!"" Ton 6/13/14 at 11:40 am, (worked 3-11 shift on 5/31/14) informed of the resident's -going nurse. The medication she did not go in and actually er she assumed her duties for e stated she was informed NA #1 that was on duty of the during the day and vomiting. e's note dated 5/31/14 at ervisor documented "Med Tech ter to come to room to assess ident's family member was that resident was not y, that she was pale in color noticed that resident was of and clammy with shallow Dxygen saturation =78%. red urine. Also, CNA informed was not able to participate in by) today. Writer, physician and ember agree to send resident			The Staff nurse is responsible to asse document, provide appropriate intervention and notify Attending Phys and Responsible Party of any acute changes in condition noted. The staf nurse will implement appropriate interventions based on the needs of t resident and notify Attending Physicia and Responsible Party. All staff nurs will document all acute changes in condition on the 24 hour report/communication board daily. Th staff nurses will communicate all acut changes utilizing the communication board during shift report. DON, ADO and Weekend Supervisor will review 24 hour/communication board utilizing 4 hour report/communication tool da ensure all acute changes are identified and followed up with an assessment/intervention and Attendin Physician and Responsible Party notification. The QI nurse, Staff Facilitator, MDS nurses, treatment nu and weekend supervisors will review progress notes utilizing a QI tool for monitoring changes in acute condition daily for 4 weeks, to include weekend and then 3 x week for 4 weeks, then weekly x 4 weeks. This review begar 6/18/14. Residents identified with an acute change in condition will have appropriate action taken to include assessment of the acute change in condition, interventions carried out, Attending Physician and Responsible Party notification. This assessment, Attending Physician, Responsible Party	sician ff the an ses the the log a aily to ed ng urse the an ds n on b			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	07/25/2014 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED C	
		345325	B. WING		06/30/2014		
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
CORNER	RSTONE NURSING AI	ND REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 157	Continued From pa	age 6	F 15	7			
		•		notifications and appropriate intervention to include but not limited to the app			
	form revealed an o for "Resident to hos in mental status, na weakness, Temper per RP (responsible =76%." On 6/13/14 at 10:33 supervisor stated s resident's room aboresident had vomite hall nurse stated sh resident a dose of a stated she was late somewhere betweet resident was just re stated she did not p of the resident at the episode. She further emesis and it looke She stated the resi her but she though supervisor further s the resident becaus admission to the fa was later called to approximately 4:45 request. She stated changed and her b RN supervisor state resident's blood pre shift but she was an	REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 6 the hospital for evaluation." eview of the "Physician Please Sign and Return" rm revealed an order dated 5/31/14 at 4:55 pm r "Resident to hospital for evaluation for change mental status, nausea and vomiting, eakness, Temperature of 99 degrees axillary er RP (responsible party) request, O2 sat 76%." n 6/13/14 at 10:32 am in an interview, the RN upervisor stated she was initially called to the sident's room about lunch time. She stated the sident had vomited a little bit and the assigned all nurse stated she was going to give the sident a dose of Zofran. The RN supervisor ated she was later told by the assigned nurse omewhere between 1pm and 2pm that the sident was just resting. The RN supervisor ated she did not personally do an assessment the resident at the time of the vomiting bisode. She further stated she looked at the nesis and it looked like the food she was eating. he stated the resident appeared edematous to er but she thought it was just obesity. The RN upervisor further stated she was not familiar with e resident because the resident was a new dmission to the facility. She further indicated she as later called to the resident's room oproximately 4:45 pm at the family member's quest. She stated the resident's color had hanged and her blood pressure was down. The N supervisor stated she was aware of the sident's blood pressure being low earlier in the hift but she was advised by the assigned nurse at the resident's blood pressure normally run		to include but not limited to the app of oxygen if o2 sats are low docum in the progress notes by the hall nu The DON will review the acute cha condition QI audit tool 5 times per y for 4 weeks and then weekly for 8 y for completion of follow up. In the absence of the DON, the ADON wi review the Acute Change in Condit Audit Tool. QI committee will review the Acute Change in Condition QI audit tool y for six months. The QI committee members consist of the QI nurse, I ADON, MDS Coordinator, Staff Fad Therapy Manager, and Administrat The Quality Assurance committee y review the results of the Acute Cha Condition Audit tool at the monthly meeting for 3 months for the need continue monitoring and the freque monitoring.	ented Irse. nge in week weeks II ion veekly DON, cilitator, or. will nge in QI to		

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		E SURVEY
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		345325	B. WING				30/2014
NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	STONE NURSING AN	ND REHABILITATION CENTER			11 SUSAN TART ROAD BOX 948		
				D	UNN, NC 28334		1
(X4) ID PREFIX		TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL	ID PREFIX	~	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	~	CROSS-REFERENCED TO THE APPRO		DATE
			1		DEFICIENCY)		
F 157	Continued From no		F 4				
1 157	Continued From pa	supervisor further stated the	F 1	57			
		aturation was 76% on room					
	air. The RN supervi	isor stated she went by the					
		er during the day but she did					
		n the resident personally old by the assigned hall nurse					
	that the resident was						
		ocumentation from the local					
		Medical Services) revealed the the facility was 5:14 pm.					
		nt record of the local					
		I Services documented on					
		revealed "it was noted that ave a radial pulse." The					
		ocumented on 5/31/14 at 5:17					
		and shallow, pulse rate 38					
		ion of 78%." Further review of					
		of the local Emergency ed "oxygen was initiated at					
		per a non-rebreather (nrb)					
		(peripheral capillary oxygen					
	saturation) and dec	reased respirations. "					
	Multiple attempts to	o contact Nurse #1 were					
		npts to contact Nurse #1 were					
	made on 6/13/14 at	12:50 pm, 2:49 pm and 5:37					
		pt to contact Nurse #1 was					
	made on 6/30/14 at	t 9:43 am.					
	On 6/13/14 at 2:55	pm in an interview, the					
	attending physician	stated it was his expectation					
		y him immediately of a change					
		lition. After discussing the for the resident having nausea					
		lood pressure reading and					
	yellow skin discolor	ation, the physician further					
		symptoms together meant					
	something was goir	ng wrong here.					

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		FORM	07/25/2014 APPROVED							
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		0MB NO. 0938-0391 (X3) DATE SURVEY			
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING _				PLETED		
		345325	B. WING	_				C 30/2014		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COD	E				
CORNER	CORNERSTONE NURSING AND REHABILITATION CENTER			711 SUSAN TART ROAD BOX 948 DUNN, NC 28334						
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH			(X5) COMPLETION		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE API DEFICIENCY)	PROPF	RIATE	DATE		
F 157	Continued From pa	ae 8	F 1	57						
_	e entande d'i reni pa	900		01						
		vas notified of the Immediate 4 at 9:10 am. The Immediate								
	Jeopardy was remo	oved on 6/30/14 at 8:59 pm.								
	i ne credible allega	tion read as follows:								
		ssessed by hall nurse on ed to have skin warm and dry,								
	breathing even and	unlabored, no productive								
		y sounds normal, 02 sats at nd vomited food. Zofran given								
	for Nausea and Vor	miting on 5/31/14 by hall nurse								
		d order. Med tech and Certified ummons nursing supervisor to								
	come to residents r	oom to assess resident on 1 was assessed on 5/31/14 by								
		sor for response, color,								
	edema, respirations Foley. The RP was	s, 02 sats, and urine color in								
	assessment of resid	dent #1 by nursing supervisor.								
		ician was made aware by nt #1 condition on being hard								
	to arouse, cool and	d clammy with shallow								
		02 sats at 76%, tea colored not able to participate in								
	therapy on 5/31/14.	A telephone order was								
	at 4:55pm for reside	From the attending physician ent #1 to be sent to (the								
		tion. Hall nurse on 7-3pm shift It #1 during the acute change								
	resigned on 6/2/14.	u								
		urses were in-serviced on								
		cilitator (Staff Educator) on to physician by telephone								
	when an acute char	nge in condition to include								
		havior, immune system ody system functioning,								
		e status, changes in behavior,								

If continuation sheet Page 9 of 30

DEPAR ⁻ CENTEI	FORM	APPROVED . 0938-0391							
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED			
		345325	B. WING _			C 30/2014			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
CORNER	CORNERSTONE NURSING AND REHABILITATION CENTER			711 SUSAN TART ROAD BOX 948 DUNN, NC 28334					
(X4) ID PREFIX TAG			ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHOUL	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 157	changes in oral inta in immune system, functioning, Panic la condition warrants la assessment; If you Physician, you may you are unable to re physician, you may Director. Notification types of changes in is not acceptable. A nurses have been in physician by telepho condition to include immune system res functioning, acute of changes in oral inta in immune system, functioning, Panic la condition warrants la assessment; If you Physician, you may you are unable to re physician, you may you are unable to re physician, you may Director; and Notifit these types of chan by fax is not accept Acute Change is de norm for a resident change in mental al increased weakness to feed, bathe, or gi balance, transfer, o change in ability to with breathing, com	ke to include fluids, changes changes in normal body aboratory values, resident's based upon nurse's are unable to reach Attending call On-call for physician; If each attending or on-call call the facility's Medical on of the physician of these a resident's condition by fax As of 6/30/14, all licensed n-serviced on notification to one when an acute change in cognitive status, behavior, sponse, normal body system change in resident condition, e status, changes in behavior, the to include fluids, changes changes in normal body aboratory values, resident's based upon nurse's a are unable to reach Attending call On-call for physician; If each attending or on-call call the facility's Medical cation of the physician of ages in a resident's condition able.	F 15	57					

		AND HUMAN SERVICES				FORM	07/25/2014 APPROVED 0938-0391	
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345325	B. WING					
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE			
CORNER	STONE NURSING AN	ID REHABILITATION CENTER			I1 SUSAN TART ROAD BOX 948 UNN, NC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 157	Continued From pa	ge 10	F 1	57				
	in last 30 days was Coordinator, MDS r improvement) nurse Facilitator on 6/19/1 6/23/14, 6/24/14, 6/ 6/28/14, 6/29/14, ar ensure residents wi in condition to inclu- mental alertness ar weakness or fatigue bathe, or groom set transfer, or walk, ch ability to chew/swal breathing, complain bowel elimination h and vomiting, and f vital signs and 02 s placed, and Attendi Party were notified resident was identif Physician notification assessed and Attern 6/19/14. This asse interventions, Atten Responsible Party r in the progress note head to toe assess ADON, (assistant d Facilitator, QI nurse nurse and Treatmen residents for any ac include but not limit alertness and orien fatigue, change in ap walk, change in ap	e, Treatment nurse and Staff 14. 6/20/14, 6/21/14, 6/22/14, 125/14, 6/26/14, 6/27/14, nd completed by 6/30/14 to ho have had an acute change de but not limited to change in nd orientation, increased e, change in abilities to feed, lf, change is sitting balance, hange in appetite, change in low food, difficulty with hts of dizziness, change in abits, complaints of nausea alls were assessed to include ats, appropriate interventions ng Physician and Responsible of acute change. One fied to not have Attending on. The resident was hding Physician notified on ssment along with						

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _			C
		345325	B. WING _				30/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	STONE NURSING AN	ND REHABILITATION CENTER			I1 SUSAN TART ROAD BOX 948 UNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	TIVE ACTION SHOULD BE	
F 157	complaints of dizzin elimination habits, o vomiting, and falls. Responsible Party v interventions initiate condition to include mental alertness ar weakness or fatigue bathe, or groom set transfer, or walk, ch ability to chew/swal breathing, complain bowel elimination ha and vomiting, and fa Attending Physician notifications and ap documented in the nurse. 100% of licensed m on notification to ph acute changes in co changes in cognitive changes to include response, normal b laboratory values, m based upon nurse's unable to reach Atte On-call for physicia attending or on-call facility's Medical Din physician of these t resident's condition licensed nurses wo notification of the pt 6/30/14. The Staff nurse is m	age 11 hess, change in bowel complaints of nausea and The Attending Physician and will be notified and appropriate ed with all identified changes in a but limited to change in nd orientation, increased e, change in abilities to feed, lf, change is sitting balance, hange in appetite, change in low food, difficulty with nts of dizziness, change in abits, complaints of nausea alls. This assessment, h, Responsible Party porpriate interventions progress notes by the hall urses have been in-serviced hysician by telephone when an ondition occur, including re status, behavior, oral fluids, immune system body system functioning, Panic esident's condition warrants is assessment; If you are ending Physician, you may call n; If you are unable to reach physician, you may call the rector. Notification of the types of changes in a by fax is not acceptable. All rking have been in-serviced in hysician completed on	F 15	57			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/25/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		345325	B. WING			30/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CORNER	RSTONE NURSING AN	ID REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157 F 309 SS=J	notify Attending Phy of any acute change staff nurse will imple interventions based and notify Attending Party. All staff nurs changes in conditio report/communicati nurses will commun- utilizing the commun- report. DON (direc: Weekend Supervise hour/communicatio report/communicatio report/communicatio report/communicatio acute changes are an assessment/inte Physician and Resp credible allegation of 6/30/14. On 6/30/14 at 9:01 allegation was evide licensed nursing sta physician related to condition. The licen examples of acute of documentation in the licensed nurses als implement medical the change in condi- interventions. 483.25 PROVIDE C HIGHEST WELL BI Each resident must provide the necessa or maintain the high	visician and Responsible Part es in condition noted. The ement appropriate on the needs of the resident of Physician and Responsible es will document all acute n on the 24 hour on board daily. The staff nicate all acute changes nication board during shift tor of nursing), ADON, and or will review the 24 n board utilizing a 24 hour on tool daily to ensure all identified and followed up with rvention and Attending bonsible Party notification. The completion date was set to be pm, verification of the credible enced by interviews of aff related to notification of changes in a resident's sed nursing staff verified changes and the need for he medical record. The o verified the need to intervention as indicated for tion and document the CARE/SERVICES FOR	F 15			7/22/14

Facility ID: 923073

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/25/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345325	B. WING			, 30/2014
NAME OF I	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	STONE NURSING AN	ID REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa accordance with the and plan of care.	ge 13 e comprehensive assessment	F 309			
	by: Based on record refacility failed to com change in a resider #1) of 3 sampled ref medical treatment of 3 residents with an greater than 15 min Jeopardy began on was notified of the 1 6/30/2014 at 9:10 a was removed on 6/ facility provided an of Compliance. The compliance at a sco harm with the poter harm that is not imm facility was in the pi and monitoring thei The findings include Resident #1 was an 5/27/14 with medica atrial fibrillation and note dated 5/28/14 the resident was all Review of a written documented "On S morning that Reside vomiting that morni	ed: Imitted to the facility on al diagnoses which included hypertension. The nurses through 5/30/14 documented		Cornerstone Nursing and Rehabili Center acknowledges receipt of the State Deficiencies and proposes this Pla Correction to the extent that the summary of fi is factually correct and in order to ma compliance with applicable rules an provisions of quality of care of residents. The Correction is submitted as a writter allegation of compliance. Cornerstone Nursing and Rehabilit Center response to this Statement of Defic does not denote agreement with the Stat of Deficiencies nor does it constitute a admission that any deficiency is accurate. Fur Cornerstone Nursing and Rehabilit Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies the Informal Dispute Resolution, format appeal procedure and/or any other admini-	ment of n of indings intain nd Plan of n ation ciencies tement an ther, ation he nrough	

Facility ID: 923073

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	ATE SURVEY OMPLETED C 6/30/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
CORNERSTONE NURSING AND REHABILITATION CENTER 711 SUSAN TART ROAD BOX 948 DUNN, NC 28334	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
 F 309 Continued From page 14 was too low and her pulse. Family member came in and said that she did not look right. I told Nurse #1 and she said that the resident was fine. I told her that morning that the woman should be sent out." On 6/13/14 at 12:09 pm NA #2 was interviewed. NA #2 worked on the 7am -3 pm shift on 5/30/14 and 5/31/14 and she was assigned to take care of the resident. NA #2 stated Resident #1 was feeling good the day before on Friday. She stated the resident stated she did not feel well on Saturday (5/31/14) morning, she stated she was nauseated. NA #2 stated she set Resident #1 up with her breakfast tray. She stated free Resident #1 took a couple of bites, she stated after Resident #1 took a couple of bites, she stated after Resident #1 took a couple of bites, she stated after Resident #1 took a couple of bites, she stated throwing up. She stated she took the resident's vital signs and recorded the vital signs on the sheet at the nurse's station. The NA stated Resident #1 did not eat lunch. The NA fatter Resident #1 did not eat lunch. The NA fatted resident's family members' concerns and the resident's family dependent with bed mobility. Pt Review of the OT (Occupational Therapy Assistant) #1 documented "Pt (patient) dependent with bed mobility. Pt 	s s y, pw s s, s

Facility ID: 923073

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		& MEDICAID SERVICES	1	—			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 06/30/2014	
		345325					
	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	00/	50/2014
		ND REHABILITATION CENTER		7'	11 SUSAN TART ROAD BOX 948 DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 309	Continued From pa	ae 15	F 3	09			
F 208	provided optimal por too fatigued and co presented with coo edema noted. After sips of beverage pa nurse to room. After withheld treatment physician and poss to vitals related to C During an interview OTA (Occupational the resident compla 5/31/14. She further resident from 12:15 approximately. She complained of feeli she scooted the rest for her lunch meal. sick and throwing u resident was puffy She further stated s The OTA further stated s The OTA further stated any kind. She further treatment meant for resident because s Nurse #1 informed physician and poss the hospital. The O 30 minutes later to could not understan been sent out to the Review of the nurse	ositioning in bed for lunch as pt implaining of nausea. Pt I moist skin and moderate a couple of bites of food and atient vomited, OTA called or nurse assessment, nursing of any kind and reports calling ible out to hospital secondary CHF (congestive heart failure)." on 6/13/14 at 12:58 pm, the Therapist Assistant) #1 stated ained of not feeling well on or stated she worked with the opm to 12:30 pm e stated the resident ng tired and sick. She stated sident up in bed to prepare her She stated the resident was up. She further indicated the and glossy from the edema. she went and got Nurse #1. ated after Nurse #1 assessed e nurse withheld treatment of er stated withholding of r her not to work with the he was too sick. She stated her that she was calling the ibly sending the resident out to TA stated she went back about check on Resident #1 and nd why the resident had not	F3	09	Facilitator, QI nurse, MDS Coordin MDS nurse and Treatment nurse of 6/30/14 on all residents for any act change in condition to include but of limited to change in mental alertne orientation, increased weakness of fatigue, change in abilities to feed, or groom self, change in sitting bal transfer, or walking ability, change appetite, change in ability to chew/f food, difficulty with breathing, decre oxygen saturation, complaints of dizziness, change in bowel elimina habits, complaints of nausea and vomiting, and falls. The Attending Physician and Responsible Party w notified and appropriate interventio initiated with all identified changes condition to include but not limited change in mental alertness and orientation, increased weakness of fatigue, change in abilities to feed, or groom self, change is sitting bal transfer, or walking ability, change appetite, change in ability to chew/f food, difficulty with breathing, decre oxygen saturation, complaints of dizziness, change in ability to chew/f food, difficulty with breathing, decre oxygen saturation, complaints of dizziness, change in ability to chew/f food, difficulty with breathing, decre oxygen saturation, complaints of dizziness, change in bowel elimina habits, complaints of nausea and vomiting, and falls. This assessme Attending Physician, Responsible F notifications and appropriate interv were documented in the progress of by the hall nurse. 100% audit was completed of MAR for all residents requiring o2 sats to ensure oxygen	n tite not ss and bathe, ance, in swallow eased tion /as ns in to bathe, ance, in swallow eased tion ent, the Party entions notes	
	alert and oriented. "resident has been	The same note documented sick this shift and has not ast, Zofran administered for			initiated as required on 6/19/14 by nurses. All identified areas of conc were immediately addressed by the	hall ern	

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If continuation sheet Page 16 of 30

CENTER	-	I AND HUMAN SERVICES & MEDICAID SERVICES				APPROVEI 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	СОМ	(X3) DATE SURVEY COMPLETED	
		345325	B. WING _			C 30/2014	
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE			
CORNER	STONE NURSING A	ND REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 309	Continued From pa	age 16	F 30	9			
	documented "resid	ng." The nurse's note further ent resting in room. Able to		nurse to include initiation of o2.			
	dry. Breathing ever tolerated well. Resi	known to staff. Skin warm and and unlabored. Meds dent has been nausea and		100% in-service was initiated wi C.N.A s, Housekeeping, Dietar Therapy staff on 6/18/14 and co	y and mpleted		
	within reach."	before lunch. Call light cord		by 7/4/14 on all shifts by the Sta Facilitator regarding observation reporting changes in resident □s	and condition		
	(MAR) for May 201 8 milligrams (mg) b	ication Administration Record 4 revealed an order for Zofran by mouth three times a day as . Further review of the MAR		promptly to the hall nurse or sup 100% in-service was initiated on and completed by 7/8/14 on the completion of The Early Warnin	6/30/14		
	did not reveal docu administration of Zo	mentation of the		Stop and Watch. This tool is to b completed by C.N.A s, licensed housekeeping, dietary, Therapy	be I nurses,		
	unsuccessful. Atter made on 6/13 at 12	o contact Nurse #1 were npts to contact Nurse #1 were 2:50 pm, 2:49 pm and 5:37 pm. contact Nurse #1 was made am.		any acute change in condition no include seems different than usu or communicates less than usual needs more help than usual, par in activities less than usual, ate usual (not because of dislike of	ual, talks al, overall rticipated less than		
	part "On Saturday, sick, sick vomiting (NA#2) took her vit she wasn't doing w	statement by NA #1 read in 5/31/14 Resident #1 was very and having diarrhea. Her Aid als and informed Nurse #1 that ell. As the day went on,		drank less than usual, weight ch agitated or nervous more than u tired, weak, confused, or drowsy in skin color or condition, and he walking, transferring, toileting m	ange, sual, ⁄, change elp with ore than		
	#1 around 2:45pm, Resident #1 becau raised her voice at	ill feeling bad. I asked Nurse what would we do about se she was still doing bad. She me and stated "I can't send and diarrhea. I then walked		usual and given to hall nurse. The nurse is to follow up on the Early Tool by assessing the resident, in to Attending Physician and Resp Party, initiate appropriate interve	Warning eporting oonsible		
	away. Around (time yellow. I told NA #3 with me. I then wer	e unclear) she was looking to look at her and she agreed at to RN supervisor and asked dent #1 and she stated "I'm		and documentation is placed in progress notes. The Early Warr will be placed in the DON mailbo review to ensure that the resider	the ning Tool ox for		
	asked to get oxyge 10-15 minutes, I lo	e called EMS!" Nurse #1 was n for Resident #1. After about oked for Nurse #1. She was at doing her MARS (Medication		assessed, reporting to Attending Physician and Responsible Part completed, appropriate interven initiated and documentation is in	y was tions		

Facility ID: 923073

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		AND HUMAN SERVICES			PRINTED: FORM OMB NO.	APPROVE
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	IPLE CONSTRUCTION	COM	E SURVEY PLETED
		345325	B. WING			C 30/2014
NAME OF	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIF		
CORNERSTONE NURSING AND REHABILITATION CENTER				711 SUSAN TART ROAD BOX 948 DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 309	Administration Rec was the oxygen? N keys to the room and She never got the or asked her to get." On 6/13/14 at 11:17 NA #1 worked the 7 was not responsible shift. NA#1 was react the 3 pm -11 pm sho Resident #1 complation beginning of the sh #1 vomited during h stated Resident #1 self. The NA further tired, sleepy and was taken the resident's the vomiting episod low. The NA stated blood pressure react #2 took the vital sig further stated she v 3 pm she was assig stated when she was shortly after 3 pm, F and her mouth was NA #3 to come and resident's color was resident was not taken further stated she v reported the finding Nurse #1 that the react well. She stated aft stopped by the Med	age 17 ords). I asked Nurse #1 where urse #1 stated "I don't have and I'm not on the hall anymore. oxygen that the RN supervisor 7 am NA #1 was interviewed. 7-3 shift on 5/31/14 but she e for this resident during this sponsible for this resident on ift on 5/31/14. NA #1 stated ained of not feeling well at the ift. She further stated Resident her breakfast meal. NA #1 was not acting her normal r stated "She was out of it, eak." NA #1 stated NA #2 had a vital signs that morning after le and the blood pressure was she remembered seeing the ding on the machine after NA ins for Resident #1. NA #1 vorked a double shift and after gned to Resident #1. She ent in to check on Resident #1 Resident #1's skin was yellow open. She stated she asked verify with her that the s yellow. She stated the lking straight to them. NA #2 vent to the nurse's station and is to Nurse #1. She stated he had given the resident arlier. The NA stated she told esident was still not feeling er she left Nurse #1, she dication Aide on duty and he resident was not feeling well	F 30	notes. Other examples of resident condition and inter- included in the in-service of mental alertness and orien increased weakness or far abilities to feed, bathe, or change in sitting balance, walk, change in appetite, or to chew/swallow food, diff breathing, decreased oxyg complaints of dizziness, c elimination habits, complar and vomiting, and falls; If acute change in a residen report it to the hall nurse in you feel that the resident in condition has not been report the change in the re- supervisor or another hall supervisor is not available the acute change has still addressed, then the DON be notified. All newly hire Housekeeping, Dietary an will be in-serviced in orien acute changes in condition licensed nurses have bee Staff Facilitator and comp regarding notification to pl telephone to include seco shift and weekends; when changes in condition occu decreased oxygen saturat immediate application of o are low, changes in cognifi- behavior, oral changes to immune system response system functioning, panic	erventions were: change in ntation, tigue, change in groom self, transfer, or change in ability iculty with gen saturation, hange in bowel ints of nausea you notice an t you must mmediately; If s acute change addressed; esident to the nurse if e; If you feel that not been or ADON must d C.N.A s, d Therapy Staff tation regarding n. 100% of all n in-serviced by leted by 6/30/14 hysician by nd shift, third a nacute ir, including tions and oxygen if sats tive status, include fluids, n normal body	

Facility ID: 923073

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/25/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		345325	B. WING			C 06/30/2014	
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	STONE NURSING AN	ID REHABILITATION CENTER			11 SUSAN TART ROAD BOX 948 UNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309			F3	309	based upon nurse s assessment; are unable to reach Attending Physi you may call On-call for physician; I are unable to reach attending or on- physician, you may call the facility Medical Director. Notification of the physician of these types of changes resident s condition by fax is not acceptable. All newly hired licensed nurses will be in-serviced in oriental notification to the physician by telep on resident acute changes in condit and immediate application of oxyge sats are low by the Staff Facilitator of orientation. The Staff nurse is responsible to as document, provide appropriate intervention and notify Attending Ph and Responsible Part of any acute changes in condition noted. The sta nurse will implement appropriate	ician, f you -call s e s in a d tion on hone tion n if o2 during sess, ysician aff	
	The medication aid medication pass. S minutes later she a and check the reside stated she was info later that the reside hospital. Review of the nurse pm by RN supervise asked writer to com (rsdt). Resident's fa stated that resident that she was pale in noticed that resider	dent that she was aware of. e stated she continued her he further stated a few sked the RN supervisor to go lent. The Medication Aide rmed by the RN supervisor nt was being sent to the e's note dated 5/31/14 at 5:31 or read "Med Tech and CNA he to room to assess resident imily member was present and was not responding normally, n color and swollen. Writer ht was hard to arouse, cool hallow respirations of 28.			interventions based on the needs of resident and notify Attending Physic and Responsible Party. All staff nur will document all acute changes in condition on the 24 hour report/communication board daily. staff nurses will communicate all ac changes utilizing the communication board during shift report. DON, AD and Weekend Supervisor will review 24 hour/communication board utilizi 24 hour report/communication tool of ensure all acute changes are identifi and followed up with an assessment/intervention and Attendor Physician and Responsible Party notification. The QI nurse, Staff	tian rses The tute n ON, v the ting a daily to fied	

Facility ID: 923073

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE			0938-039
ID PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED C	
		345325	B. WING			06/3	30/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	STONE NURSING AN	ND REHABILITATION CENTER			11 SUSAN TART ROAD BOX 948 UNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	Continued From pa	ge 19	F 3	09			
	Oxygen saturation a urine. Also, CNA int not able to participat today. Writer, physi member agree to s evaluation. See VS family member to m Review of the writter read in part "On M was called to (Resident entered the room, N some vomitus off th vomitus appeared to was eating. Then a (Resident #1's) roo greeted by the resident asked if I could help her what she needed Resident #1 was not what she thought w #1. She told me that that her color was r acting right. I told the that I could send Re for evaluation and se resident's family me quickly assessed the attending physician offer to get the oxyg because EMS had after a few minutes gotten there, I aske get oxygen. CNA ca stated that Nurse #	=78%. Foley with tea colored formed writer that resident was ate in PT (physical therapy) ician and resident's family end resident to the hospital for 's (vital signs). Resident's neet resident at the hospital." en statement by RN supervisor ay 31st around lunchtime, I dent #1's) room. When I Nurse #1 was cleaning up he resident's gown. The to be some of the food resident round 4:45 pm, I was called to m again. This time I was dent's family member who to her with Resident #1. I asked ed me to do and she stated of doing good. I asked her vas different about Resident at Resident #1 was swollen, not good and that she was not he resident's family member esident #1 out to the hospital she agreed. After the ember was out of the room, I he resident. EMS and the were called. Nurse #1 did gen but did not immediately already been called. However and the fact that EMS had not ed the CNA to have Nurse #1 ame back to the room and 1 said she was off the floor needed to get the oxygen.		09	Facilitator, MDS nurses, treatment of and weekend supervisors will review progress notes utilizing a QI tool for monitoring changes in acute conditi daily for 4 weeks to include weeken then 3 times a week for 4 weeks the weekly x 4 weeks. This review beg 6/18/14. Residents identified with a acute change in condition will have appropriate action taken to include assessment of the acute change in condition, interventions carried out, include but not limited to application oxygen if o2 sats are low, Attending Physician and Responsible Party notification by the hall nurse. This assessment, Attending Physician, Responsible Party notifications and appropriate interventions document the progress notes by the hall nurse DON will review the acute change in condition QI audit tool 5 times per w for 4 weeks, and then weekly for 8 w for completion of follow up. In the absence of the DON, the ADON will review the Acute Change in Condition Audit Tool. QI committee will review the Acute Change in Condition QI audit tool w for 3 months. The QI committee members consist of the QI nurse, D ADON, MDS Coordinator, Staff Fac Therapy Manager, and Administrator The Quality Assurance committee v review the results of the Acute Charge	w the ion ids and en an on an to n of d ted in e. The n veek weeks l on veekly on veekly con, cilitator, or. will nge in	

Facility ID: 923073

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		AND HUMAN SERVICES				FORM	07/25/2014 APPROVED 0938-0391	
-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	COM	E SURVEY PLETED	
		345325	B. WING			C 06/30/2014		
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CORNE	RSTONE NURSING AN	ND REHABILITATION CENTER			11 SUSAN TART ROAD BOX 948 JUNN, NC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	On 6/13/14 at 10:32 supervisor stated s resident's room aboresident had vomite hall nurse stated sh resident a dose of 2 stated she was late somewhere betwee resident was just resident was just resident was just resident at the episode. She further emesis and it looke She stated the resident at the emesis and it looke She stated the resident becaus admission to the fa was later called to the approximately 4:45 request. She stated concerned about the not acting right. She had changed and he The RN supervisor resident 's blood pushift but she was about that the resident's blood pushift but she was about personally review the pressures. The RN resident's oxygen saturation but and they usually ge She further stated the	2 am in an interview, the RN he was initially called to the but lunch time. She stated the ed a little bit and the assigned he was going to give the Zofran. The RN supervisor or told by the assigned nurse en 1pm and 2pm that the esting. The RN supervisor bersonally do an assessment he time of the vomiting er stated she looked at the ed like the food she was eating. dent appeared edematous to t it was just obesity. The RN stated she was not familiar with se the resident was a new cility. She further indicated she	F 3	09	monitoring.			

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		AND HUMAN SERVICES			FORM	APPROVED 0938-0391	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY
			A. BUILDI	NG			C
		345325	B. WING			06/3	30/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CORNE	RSTONE NURSING AN	ND REHABILITATION CENTER			11 SUSAN TART ROAD BOX 948 DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	oxygen to the residu she was later told a the hospital that the participate in therap was too weak. The went by the residen but she did not stop personally because hall nurse that the r Review of the "Phys form revealed an or for "Resident to hos in mental status, na weakness, Tempera per RP (responsible =76%." Review of the Emer Report dated 5/31/7 was found lying in to was very pale almo neck up." Review of written de EMS (Emergency N the 911 call was plat of the EMS unit arri Review of the patie emergency services read, " it was noted radial pulse." The p 5/31/14 at 5:17 pm pulse rate 38 and o Further review of the emergency services initiated at 5:18 pm	ent. The RN supervisor stated after she sent the resident to e resident was not able to by that morning because she RN supervisor stated she nt's room later during the day to check on the resident e she was told by the assigned resident was resting. sician Please Sign and Return" rder dated 5/31/14 at 4:55 pm spital for evaluation for change ausea and vomiting, ature of 99 degrees axillary e party) request, O2 sat rgency Medical Services 14 documented "the patient bed not real responsive and bast light blue in color from the ocumentation from the local Medical Services) documented aced at 5:00 pm and the time ival to the facility was 5:14 pm. ent record of the local s dated on 5/31/14 at 5:16pm d that the patient didn't have a batient record documented on "Respirations 8 and shallow, bygen saturation of 78%." he patient record of the local s documented "oxygen was	F 3	09			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	07/25/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		345325	B. WING		C 06/30/2014	
NAME OF F	PROVIDER OR SUPPLIER	·	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CORNER	STONE NURSING AN	ND REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From pa	ige 22	F 309			
	decreased respirati documented on 5/3	y oxygen saturation) and ions." The same report 31/14 at 5:28 pm read "the rted to improve and her color rove."				
	report documented	hospital Emergency Room when EMS arrived, the ly a blunted (sic) and blood 60 systolic."				
	attending physician is evaluated, the mo- be different for the r reports per the staff and vomiting, low b yellow skin discolor	pm in an interview, the stated the sooner a resident ore likely the outcome would resident. After discussing the f of the resident having nausea blood pressure reading and ration, the physician further symptoms together meant ng wrong here."				
	Director of Nursing was initiated on 6/2 for Resident #1. Th facility was not awa readily accessible to which time the lock	6/30/14 at 11:38 am, the (DON) stated an investigation 2/14 regarding the care delivery the DON further revealed the are of the oxygen not being to the nurses until 6/18/14 at a on the oxygen room was ad where a key would not be				
	Director of Emerge #1 was cyanotic (bl oxygen on EMS arr stated the resident at the wrist due to the stated EMS was no	on 6/30/14 at 11:48 am, the ency Services stated Resident lue in color) from a lack of rival to the facility. He further did not have a palpable pulse the low blood pressure. He ot able to obtain a blood tt the first obtainable blood				

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		AND HUMAN SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL		OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
							С
		345325	B. WING			06/:	30/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	STONE NURSING AN	ND REHABILITATION CENTER			DUNN, NC 28334		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
F 200	O setting of From an	<u></u>	- -	~~~			
F 309	Continued From pa	•	F 3	09			
	2014.). The resident died on June 1,					
	The facility provider	d the following Credible					
		30, 2014 at 8:59 pm.					
	Credible Allegation	of Compliance: F-Tag 309					
	For the Provision of	f Care to Maintain the highest					
	level of function for						
	Completion date 6/3	30/14					
	· Resident # 1 wa	as assessed by hall nurse on					
		red to have skin warm and dry,					
		l unlabored, no productive g sounds normal, 02 sats at					
		nd vomited food. Zofran given					
	for Nausea and Vor	miting on 5/31/14 by hall nurse					
	•	d order. Med tech and Certified					
		ummons nursing supervisor to room to assess resident on					
		#1 was assessed on 5/31/14					
		ervisor for response, color,					
		s, 02 sats, and urine color in					
	foley. The RP was	dent #1 by nursing supervisor.					
		ician was made aware by					
	telephone of reside	nt #1 condition on being hard					
		d clammy with shallow					
		02 sats at 76%, tea colored ot able to participate in therapy					
		phone order was received on					
	5/31/14 from the at	tending physician at 4:55pm					
		e sent to Betsy Johnson					
	Hospital for evaluat	tion. Hall nurse assigned to					

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DEPART	FORM	APPROVED					
CENTERS FOR MEDICARE & MEDICAID SERVICES							0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
			A. BUILDII	10			C
		345325	B. WING				30/2014
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		
				D	UNN, NC 28334		
(X4) ID PREFIX			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP		DATE
			1	_	DEFICIENCY)		
F 309	Continued From no	ao 04	Бой	~~			
1 303	Continued From pa	•	F 30	19			
		he acute change resigned on ensed nurses were in-serviced					
		Facilitator (Staff Educator)					
		on to physician by telephone					
		nge in condition to include havior, immune system					
	0	ody system functioning,					
		e status, changes in behavior,					
		ke to include fluids, changes					
		changes in normal body					
		aboratory values, resident ' s based upon nurse ' s					
		are unable to reach Attending					
	Physician, you may	call On-call for physician; If					
		each attending or on-call					
		call the facility 's Medical on of the physician of these					
		a resident 's condition by fax					
		As of 6/30/14, all licensed					
		in-serviced on notification to					
		one when an acute change in cognitive status, behavior,					
		sponse, normal body system					
		hange in resident condition,					
	5	e status, changes in behavior,					
		ke to include fluids, changes changes in normal body					
		aboratory values, resident 's					
	condition warrants I	based upon nurse ' s					
		are unable to reach Attending					
		call On-call for physician; If each attending or on-call					
		call the facility 's Medical					
	Director; and Notifi	cation of the physician of					
		ges in a resident 's condition					
	by fax is not accept	adie.					
	· Acute Change i	is defined as anything outside					
		lent to include but not limited					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	07/25/2014 APPROVED 0938-0391	
		(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED C				
		345325	B. WING			06/30/2014		
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
CORNER	RSTONE NURSING A	ND REHABILITATION CENTER			11 SUSAN TART ROAD BOX 948 UNN, NC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	STONE NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 to change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change is sitting balance, transfer, or walk, change in appetite, change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting, and falls. 100% audit of all residents daily progress notes in last 30 days was initiated by MDS nurse Coordinator, MDS nurse, QI nurse, Treatment nurse and Staff Facilitator 6/19/14, 6/25/14, 6/26/14, 6/27/14, 6/28/14, 6/29/14 and completed by 6/30/14 to ensure residents who have had an acute change in condition to include but not limited to change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change is sitting balance, transfer, or walk, change in appetite, change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting, and falls were assessed to include vital signs and 02 sats, appropriate interventions placed, and Attending Physician and Responsible Party were notified of acute change. One resident was identified to not have Attending Physician notification. The resident was assessed and Attending Physician notified on 6/19/14. This assessment along with interventions, Attending Physician and Responsible Party notification will be documented in the progress notes by the hall nurse. 100% head to toe assessment was completed by ADON, Staff Facilitator, QI nurse, MDS Coordinator, MDS nurse and Treatment nurse on 6/30/14 on all residents for any acute		F 3	09				

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		AND HUMAN SERVICES		FORM	APPROVED		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY	
	FCORRECTION	IDENTIFICATION NUMBER:	• •				PLETED
						(C
		345325	B. WING			06/3	30/2014
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CORNERSTONE NURSING AND REHABILITATION CENTER					1 SUSAN TART ROAD BOX 948 UNN, NC 28334		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
-					DEFICIENCY)		
F 309	Continued From pa	ge 26	F 30	29			
		to include but not limited to					
		lertness and orientation,					
		s or fatigue, change in abilities room self, change is sitting					
		r walk, change in appetite,					
		chew/swallow food, difficulty					
		plaints of dizziness, change in					
		abits, complaints of nausea					
		alls. The Attending Physician arty will be notified and					
		ntions initiated with all					
		in condition to include but					
		mental alertness and					
		ed weakness or fatigue,					
		o feed, bathe, or groom self, lance, transfer, or walk,					
	change in appetite,						
		difficulty with breathing,					
		ness, change in bowel					
		complaints of nausea and					
		This assessment, the					
		n, Responsible Party propriate interventions will be					
		progress notes by the hall					
	nurse.						
		e was initiated with all C.N.A'					
		Dietary and Therapy staff on by Staff Facilitator regarding					
		porting changes in resident 's					
		to the hall nurse or supervisor.					
		as initiated on 6/30/14 on the					
		Early Warning Tool "Stop and					
		b be completed by C.N.A's,					
		busekeeping, dietary, Therapy					
		change in condition noted to erent than usual, talks or					
		than usual, overall needs					
		al, participated in activities					

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		AND HUMAN SERVICES				FORM	07/25/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345325	B. WING			C 06/30/2014	
NAME OF	PROVIDER OR SUPPLIER	•	· [STF	REET ADDRESS, CITY, STATE, ZIP CODE	•	
CORNE	CORNERSTONE NURSING AND REHABILITATION CENTER				I SUSAN TART ROAD BOX 948 INN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	PROVIDER OR SUPPLIER		F 3	09			

Facility ID: 923073

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	FOR	M APPROVED					
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	. ,	A. BUILDING			OMPLETED
							С
		345325	B. WING			0	6/30/2014
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 JUNN, NC 28334		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	ON	(X5)
PRÉFIX			PREFIX		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC		COMPLETION DATE
TAG	REGULATORTOR	SCIDENTIFTING INFORMATION)	TAG		DEFICIENCY)	FRIATE	
			1				
F 309	Continued From pa	ae 28	F 30	na			
	•	to work until in-serviced. All	1.00				
		s, Housekeeping, Dietary and					
	2	e in-serviced in orientation					
		anges in condition. 100% of all					
		ve been in-serviced on					
		cian by telephone to include					
		shift and weekends; when an					
		ondition occur, including e status, behavior, oral					
		fluids, immune system					
		ody system functioning, Panic					
		esident 's condition warrants					
		s assessment; If you are					
		ending Physician, you may call					
		n; If you are unable to reach					
		physician, you may call the					
		Director. Notification of the ypes of changes in a resident '					
		s not acceptable. All licensed					
		ve been in-serviced in					
		hysician completed on					
		nired licensed nurses will be					
		tation on notification of					
	physician on reside	nt acute changes in condition.					
	· The Staff nurse	e is responsible to assess,					
		appropriate intervention and					
		/sician and Responsible Part					
		es in condition noted. The					
	staff nurse will imple						
		I on the needs of the resident					
		Physician and Responsible					
		es will document all acute					
	changes in conditio	on board daily. The staff					
		nicate all acute changes					
		nication board during shift					
		N, and Weekend Supervisor					
		our/communication board					

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		AND HUMAN SERVICES				FORM	07/25/2014 APPROVED 0938-0391	
				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345325	B. WING			C 06/30/2014		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•		
CORNER	STONE NURSING AN	ND REHABILITATION CENTER			I1 SUSAN TART ROAD BOX 948 UNN, NC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	to ensure all acute followed up with an Attending Physician notification. On 6/30/2014 at 8:6 credible allegation v licensed nursing sta assessment and do record. Nurses veri resident exhibiting a document the findir and responsible pa allegation was also staff on reporting ch continuing up to the The staff verified th WATCH document	ge 29 eport/communication tool daily changes are identified and assessment/intervention and a and Responsible Party 59 pm, verification of the was evidenced by interviews of aff related to acute changes, boumentation in the medical fied the need to assess a a change in condition, ngs and notify the physician rty. Verification of the credible evidenced by interviews of all hange to the hall nurse be DON or ADON if necessary. e implementation of the STOP ation to be completed when a is identified in a resident.	F 3	09				

Facility ID: 923073

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