PRINTED: 10/14/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		345072	B. WING		00	C
NAME OF F	PROVIDER OR SUPPLIER	343072	D. Wille	STREET ADDRESS, CITY, STATE, ZIP CODI	<u> </u>	/19/2014
CAROLI	NA RIVERS NURSING	AND REHABILITATION CENTER	R	1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	-S	F 0	000		
F 157 SS=J	(DHSR), Nursing H Certification Section investigation survey 09/19/2014. It was substandard quality jeopardy level and a conducted. The imm 09/12/2014 and wa 483.10(b)(11) NOTI (INJURY/DECLINE) A facility must immed consult with the resident involving the injury and has the printervention; a significantly (i.e., a existing form of treat consequences, or to treatment); or a decitive resident from the status in either life to consequences, or to treatment); or a decitive resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences, or to the resident from the status in consequences.	n conducted a complaint v 09/17/2014 through decided that the facility had v of care at the immediate a partial extended survey was nediate jeopardy began on s removed on 09/19/2014. FY OF CHANGES	F1	57		10/20/14
L ABORATORY	L Z DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

BURATURY DIRECTUR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

10/07/2014

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345072	B. WING		09/1) 19/2014
	PROVIDER OR SUPPLIER	G AND REHABILITATION CENTER	. 1	STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	1 03/1	10/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	the address and p legal representativ	age 1 ecord and periodically update hone number of the resident's re or interested family member. ENT is not met as evidenced	F 157			
	by: Based on observatinterviews and phyfailed to notify the emergent condition from both ears, for reviewed for an admediate jeopard the resident was foblue lips, bleeding her face, and staff the hospital for apchange in condition Administrator was Jeopardy on 9/18/Jeopardy was remark. The facility relower scope and sharm with potentiat that is not immediate ompletes the star was in the process implementation of The findings included Resident #1 was a 04/18/2012 from a cumulative diagnot contractures, dyspersided to not some process.	ation, record review, staff visician interviews, the facility primary physician of an involving a resident bleeding of 1 of 4 residents (Resident #1) atte change of condition. By began on 09/12/2014 when bound to have a purple face, out of both ears, a bruise on delayed calling for transport to proximately five hours after the notified of the Immediate 14 at 7:41 PM. Immediate 14 at 7:41 PM. Immediate 15 are all for more than minimal harm are jeopardy, while the facility of training required. The facility of monitoring the their corrective action. In acute care hospital. Her sees included multiple shagia, muscle weakness, age, depression, cerebral artery		Carolina Rivers Nursing and Rehabilitation Center acknowledge receipt of the Statement of Deficier and proposes this plan of correction extent of findings is factually correction order to maintain compliance with applicable rules and provisions of correction is submitted as a written allegation of compliance. Carolina River's response to this Statement of Deficiencies does not denote agreement with the Statement Deficiencies nor does it constitute a admission that any deficiency is activated any of the deficiencies on Statement of Deficiencies through Informal Dispute Resolution formal procedure and/or any other administor legal proceeding. F157-MD Notification Resident #1 was observed on 9 at approximately 6:30am by CNA (I with flushed skin and blood coming resident ears. CNA notified nurse or resident flushed skin and blood corrections.	ent of an curate. he right this appeal strative	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345072	B. WING			C 19/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•		
045011	LA DIVEDO MUDOINA	2 AND DELIABILITATION OF NEED		1839 ONSLOW DRIVE EXTENSION			
CAROLII	NA RIVERS NURSING	G AND REHABILITATION CENTER		JACKSONVILLE, NC 28540			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 157	6/19/14, indicated term memory probability was severel MDS indicated the understood, requir mobility, had contrextremities and cothe MDS, the staff mood did not indic symptoms of deprobehaviors. Documentation in reviewed for the evidated 09/12/2014 resident was in bewas incontinent an repositioning. The acute changes or signed by Licensed The next entry was and read, "CNA (Nothat resident was to Resident had blooker face was slight stated the Resider sat) was 92%. Afteoxygen the O2 sat was 134/58 and he indicated the Directinformed, a voicenthe attending phys to reach the response The note was sign	dinimum Data Set (MDS) dated the resident had long and short lems and decision making y cognitively impaired. The resident was rarely or never ed total assistance for bed actures in both lower uld not ambulate. According to assessment of the resident's ate the presence of any ession, mood disorder or Resident #1's record was vents on 09/12/2014. An entry at 12:15 AM, indicated the d with her eyes closed, that she d required staff turning and entry stated there were no signs of distress. The note was d Practical Nurse (LPN) #1. Is dated 09/12/2014 at 6:51 AM Nursing Assistant) informed me oleeding out of her ears. In domining out of her ears and the purple. The note also at your property, the blood pressure was 97%, the blood pressure eart rate was 98. The note eart rate was 98. The note ician and the nurse was unable nsible party (RP) by phone.	F 1	from resident #1 ears on 9/7 assessed resident #1 at app 6:45 am on 9/12/14 with O2 92% and skin color slightly p applied O2 and sats went to pressure 134/58 and heart r Resident #1 was reassesse at approximately 7:00 am by and first shift nurse with no bleeding noted. First shift nu to assess resident #1 on 9/7 am with no active bleeding of shift nurse reassessed resid 9/12/14 around 9:30 am and rash on resident face and lig discoloration to resident face 9:30 am the MD (physician) was made aware by first shift bleeding from resident #1 ex rash on face, and light discoveresident face. Resident #1 v by first shift nurse again at a 10:30 am an observed dark resident seyes. On 9/12/14 nurse contacted MD office r and notified of darkening un resident seyes. Order rece office nurse on 9/12/14 app 11:48am MD order was writt resident to ER. Hall nurse a resident #1 during the acute drug tested and suspended Administrator on 9/15/14. C to resident #1 during the acute drug tested and suspended Administrator on 9/16 inservice was initiated on 9/ additional inservice was initiated	proximately sats range at purple. Nurse 97%, blood rate 98. don 9/12/14 y the third shift active urse continued 12/14 at 8:30 observed. First dent #1 on dobserved a ght e. On 9/12/14 office nurse iff nurse of ars at 6:30am, bloration to was assessed approximately ening under 4 first shift nurse again der eived from MD roximately at ten to send ssigned to e change was by the NA assigned ute change in and drug tested 6/14. An 12/14 and an		
		esident #1 was to be sent to		9/16/14 with both in-services			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			
		245072	B. WING			0
		345072	b. WING		•	19/2014
NAME OF F	PROVIDER OR SUPPLIER	l .		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
CAROLII	NA RIVERS NURSIN	G AND REHABILITATION CENTER	1	1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	At 12:05 PM on 09 read, "Resident be shift. No bleeding to upper face and noted. Resident con NC (nasal cannula than usual. MD (planswer at RP's nu note was signed by the shift. No bleeding to upper face and Upon starting shift around eyes appet throughout the shift around eyes appet throug	gency room for evaluation. 2/12/2014 the progress note eing assessed throughout the noted thus far, but a rashy area dark circles to Bilat (both) eyes ontinues on 2L (2 liters) O2 via a). Resident grimacing more hysician) made aware. No mber. DON made aware. This y LPN#2. 2/2014 at 12:15 PM eing assessed throughout the noted thus far, but a rashy area dark circles to Bilat eyes noted. In the later than usual area to slowly darken ft. Resident continues on 2L O2 grimacing more than usual. MD enswer at RP's number. DON the note was signed by LPN#2. 2/2014 grimacing more than usual mount and ecchymosis around eyes, there are bruises along the are suspicious for finger and about elder abuse and lation. Will notify DSS ocial Services) and plan to the er safety until this situation can a to (patient) is nonverbal but anyone hurt her, her eyes began export was signed by Hospital	F 1	100% by 9/18/14 with all oth nurses by the Staff Facilitate Educator) to include LPN #1 LPN #3, and LPN #4 regards acute changes in condition, resident out if unable to confexamples of acute changes abnormal bleeding, notificati physician by telephone where change in condition to include status, behavior, immune sy response, normal body syste functioning, changes in cognichanges in behavior, change intake to include fluids, change in tunctioning, Panic laboratory resident so condition warrant nurse sassessment; If you to reach Attending Physician On-call for physician; If you reach attending or on-call physician of changes in a resident so fax is not acceptable. Hands staff for reference. No nurse allowed to work without first in-services. "Acute Change is defined outside the norm for a reside but not limited to abnormal be color changes, changes in be change in mental alertness a orientation, increased weak fatigue, change in abilities to or groom self, change is sitting to groom self.	or (Staff, LPN #2, ng assessing sending sendin	
		ort (dated 09/12/2014) puterized Tomography (CT)		transfer, or walk, change is sitti		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED
		345072	B. WING		C 09/19/2014
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 839 ONSLOW DRIVE EXTENSION	00/10/2011
CAROLII	NA RIVERS NURSING	S AND REHABILITATION CENTER	J	IACKSONVILLE, NC 28540	
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 157	Continued From pa	age 4	F 157		
	mass or hematomatindings.	for a fracture, there was no a and no other significant		change in ability to chew/swallow for difficulty with breathing, complaints dizziness, change in bowel eliminati habits, complaints of nausea and	of
	Hospital Physician	on 09/19/2014 at 9:51 AM, #1 discussed her findings		vomiting, and falls.	
	afternoon of 09/12	nination of Resident #1 on the //2014. Hospital Physician #1 to the bruising around her		" 100% of all current residents we physically observed for acute chang condition to include changes in skin	jes in
	eyes and on her no bruise on her uppe	eck, Resident #1 also had a r arm when she came into the ment (ED). Hospital Physician		and bleeding on 9/15/14 by DON Di of Nurses), Staff Facilitator, QI (Qu Improvement) nurse, MDS (Minimul	rector ality
	that would have ca	1 wasn't on any medications used the petechiae or bruising. #1 said, "Very few things will		Data Set) nurses (2) and facility consultant. Four concerns were not during this audit and corrected by the	
	cause that petechia distinctive,- pathog	al rash. It is forensically nomonic [specifically		treatment nurse on 9/15/14 and 9/10 with interventions placed, MD and F	6/14 RP
	a sign or symptom	disease or condition; denoting on which a diagnosis can be cian further stated, "The		(resident representative) notification documentation in the progress note: Three months of nurse□s notes we	S.
	petechial rash is in crushing force. I co	dicative of strangulation or a buld not find anything else that		reviewed to ensure all documented changes in condition to include char	acute
		d it with this patient." n from Resident #1's admitting		skin color and bleeding have been addressed with appropriate interven placed, Attending Physician notification	
	hospital physician	(Hospital Physician #2) dated		and Responsible Party notification of acute change on 9/15/14 by DON, S	of the
	ecchymosis (bruisi	for large periorbital, infraorbital ng under and around the		Facilitator nurse, QI nurse, MDS nur (2) and facility consultant. Two cond	
	lip up to the forehe	a petechial rash from the upper ad." The document also s a little bit of petechial rash		were noted during this audit with reassessment of the resident by the treatment nurse on 9/16/14, no cond	
	"on the left side of #2's assessment in	the neck." Hospital Physician ncluded, "Petechial rash. Is it a		observed during the reassessment, documentation in the progress note	and
	home staff and the	se? We spoke with the nursing y truly do not have any idea of atient is not ambulatory. She is		" An inservice was initiated with of license nurses to include agency	
		o there was no history of a fall.		nurses and LPN #1, LPN #2, LPN # LPN #4 initiated on 9/12/14, on	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		E SURVEY PLETED
			A. BUILDIN			
		345072	B. WING _			19/2014
NAME OF	PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP COI		
0.1.00.11				1839 ONSLOW DRIVE EXTENSION		
CAROLI	NA RIVERS NURSIN	G AND REHABILITATION CENTER		JACKSONVILLE, NC 28540		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 157	09/18/2014 at 10:4 has so many unex life-threatening inj possible causes for Hospital Physician the ears was usual fracture or very for stated that petech strangulation or for nursing home had Hospital Physician cranial fracture but tissue in her face a subconjunctival her #2 said, "I don't k cause all of that or you rule out a fall, Hospital Physician still in the hospital The facility provides statements from the 109/15/2014 througe each written state interviewed during On 09/16/2014 Nu "(Resident #1) had of in the last 2 wks an interview was considered to 109/18/2014 at 10:4 was working the 1 provided care for liperson who discovers. At approximations are subconsidered to 109/18/2014 at 10:2 was working the 1 provided care for liperson who discovers. At approximations are subconsidered to 109/18/2014 at 10:2 was working the 1 provided care for liperson who discovers. At approximations are subconsidered to 109/18/2014 at 10:2 was working the 1 provided care for liperson who discovers. At approximations are subconsidered to 109/18/2014 at 10:2 was working the 1 provided care for liperson who discovers. At approximations are subconsidered to 109/18/2014 at 10:2 was working the 1 provided care for liperson who discovers.	a #2 was interviewed on 44 AM and said, "This patient splained injuries. These were uries." When asked about or the bleeding from the ears, a #2 stated that bleeding from ally associated with a skull reeful coughing. She further iae is often found with reeful vomiting and that the said there was no vomiting. a #2 said that tests showed no to there was swelling of the soft and neck, bruising, and emorrhaging. Hospital Physician now of anything that could ther than strangulation when a vomiting or forceful cough." a #2 indicated Resident #1 was refacility staff taken on the facility staff taken on the facility staff taken on the facility staff were	F 15	assessment of acute changes condition, sending resident or notify MD, notification to phys telephone to include second shift and weekends; when an changes in condition occur, ir abnormal bleeding, changes status, behavior, oral changes fluids, immune system respondody system functioning, Par values, resident so condition obased upon nurse sassess are unable to reach Attending you may call On-call for physician, you may call the famedical Director. Notification physician of these types of chresident completed on 9/18/14 by Staf In-service was initiated on 9/1 completed on 9/21/14 by Staf with all license nurses to inclute LPN #2, LPN #3, and LPN #4 Notifying the MD through the office hours and location of an umbers. All newly hired lice and newly assigned agency sin-serviced in orientation on the physician of acute change condition and the after-hours of MD. "The staff nurse is responsible Pacute changes in condition notify Attended the physician and Responsible Pacute changes in condition notify acute changes in condition notification acute ch	at if unable to dician by shift, third acute including in cognitive is to include inse, normal including including including include inse, normal including	

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED	
				P. WING		С	
		345072	B. WING			19/2014	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 157	Resident #1 was faright side and her saw blood on sheet together on the pillo idea where the blood to look." NA #1 turn "and the blood pour turned her on her bnurse. NA#1 report were available but the doing care and she her to Resident #1's back to the room are resident she left to that when she start and turned her over ear. Nursing Assistant (lincluded, "I got dor and as I was making station I bumped in #1) was bleeding. A that her face was b blood in her ears." the survey on 9/18/was through with me saw bound in her was through with me saw belood in her ears."	ge 6 r her face. NA#1 said cing the door, laying on her heet was on the floor. NA#1 r, and spots of blood, close ow in front of her face. I had no od was coming from, so I went hed the resident on her back, red out of her (left) ear" so she ack and went to look for the ed that neither of the nurses the NA from the 100 hall was motioned for her to come with s room. NA#1 and NA#2 went he was motioned for her to come with s room. NA#1 and NA#2 went he so get LPN#1. NA#1 stated ed to clean Resident #1 up r blood came out of the other NA) #2's undated statement he caring for my residence(sic) g my way to the back nurses to (NA#1) who said (Resident has I enter the room I noticed flue and that their (sic) was NA#2 was interviewed during 2014 at 5:20 PM, and said, "I y rounds and saw (NA#2) was boom and she said (Resident	F 1	9/18/14 the after-hours MD not number was posted at each nustation by the DON. If the staff unable to reach the attending puthe on-call MD must be called. contact the attending or the on the nurse must call the Medica The staff nurse will implement interventions based on the neeresident and notify Attending Pland Responsible Party. Staff with the DON or on-call nurse of an changes. DON, QI nurse, Staff and MDS nurses were in-service Administrator on 9/16/14 concert they are on-call and they received concerning a change in condition resident that they are to ask minguestions, if needed, to get a confidence of what is occurring with the resto insure that the nurse has no MD of the acute change. A QI Change Call Log, will be used On-Call nurse and the Administreview weekly. The DON will determine if the achange in condition reported by nurse fits the definition of an in	rse solutions in the state of the call MD, appropriate do of the call motify and the call motify and the call motify and the call control of a call call of a call of		
	where. So I followe (Resident #1's) face bleeding." NA#2 sa and she told me to On 09/15/2014 LPN of 6:30-6:45ish am,	nd she didn't know why or d into the room and her e was blue and we noticed her aid, "I left to go find a nurse get her vitals (vital signs)." I#1 wrote, "Between the times CNA came and told me that blood coming out of her ear		unknown origin-Injury of any ty occurs where the cause or confactor is not known or determinacute change in condition fits t definition of an injury of unknown then the abuse/injury of unknown procedure will be followed to in procedure for all allegations of	be that tributing ed. If the ne vn origin clude: The abuse and		
	(Resident #1) had b	CNA came and told me that blood coming out of her ear rple in her face. I ran to the		injury of unknown origin is as for employee accused of abuse w	ollows: Any		

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NAME OF PROVIDER OR SUPPLIER	STATEMENT	OF DEFICIENCIES OF CORRECTION	FICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY			
STREET ADDRESS, CITY, STATE, ZIP CODE 1833 ONSLOW DRIVE EXTENSION DRIVE EXTENSIO								
CAROLINA RIVERS NURSING AND REHABILITATION CENTER X(x) D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE DAT			345072	B. WING				
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 157 Continued From page 7 room with my vital sign equipment. Her pulse was high and her O2 was in the low 90s after getting oxygen put on her at 2L resident's vitals were re-taken and after were good within normal limits." LPN#1 was interviewed during the survey on 09/18/2014 at 11:14 AM and said she had given the resident her scheduled medications (Synthroid and Prilosec) around 6AM and had not noticed any agitation at that time or earlier in the night. LPN#1 stated that the resident had blood coming out of her ear. I think it was her left ear. I got vital signs right away. She had blood coming out of her ear and she was purple in her face like she wasn't gushing but was actively flowing." LPN#1 stated that the resident's ears LPN#1 replied, "I would say it was like a nose bleed. It wasn't gushing but was actively flowing." LPN#1 stated that she called LPN#2 and #3. She indicated LPN #2 went to get the oxygen adultation level "started to come up and color started to come up and told her everything that was going on, - the blood, purple and O2 and that her vital signs were okay. I called the doctor and left a message. The next nurse came on and I told her everything." When asked about what might cause bleeding from both ears, LPN#1 said, "I orth know."			AND REHABILITATION CENTER		18	839 ONSLOW DRIVE EXTENSION		
room with my vital sign equipment. Her pulse was high and her O2 was in the low 90s after getting oxygen put on her at 2L resident's vitals were re-taken and after were good within normal limits." LPN#1 was interviewed during the survey on 09/18/2014 at 11:14 AM and said she had given the resident her scheduled medications (Synthroid and Prilosec) around 6AM and had not noticed any agitation at that time or earlier in the night. LPN#1 stated that the resident had not had problems during the night and no one had reported any fall or agitation with regard to Resident #1. When asked how she had learned of the resident's condition that morning LPN#1 said, "(NA#2) reported it to me. She said (Resident #1) was slightly purple in her face and she had blood coming out of her ear. I think it was her left ear. I got vital signs right away. She had blood coming out of her ear and she was purple in her face like she wasn't getting enough oxygen." When asked about the amount of blood coming from the resident's ears LPN#1 replied, "I would say it was like a nose bleed. It wasn't gushing but was actively flowing." LPN#1 stated that she called LPN#2 and "1, called the DON and I told her everything that was going on, - the blood, purple and O2 and that her vital signs were okay. I called the doctor and left a message. The next nurse came on and I told her everything that was going on, - the blood, purple and O2 and that her vital signs were okay. I called the ODN and I told her everything that was going on, - the blood, purple and O2 and that her vital signs were okay. I called the Octor and left a message. The next nurse came on and I told her everything that was going on, - the blood, purple and O2 and that her vital signs were okay. I called the Ottor and left a message. The next nurse came on and I told her everything in the resident so and the resident so and the resident so and the resident in the medical record. Corrective measures will be intitated immediately reresident. Statements will be obtained from identified empl	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETION
On 09/15/2014 LPN#2's statement included that LPN#1 had called for assistance and when she documentation, weekly X□s 4 weeks and then monthly X□s 3 months to insure that if resident has a change in condition that it	F 157	room with my vital shigh and her O2 was oxygen put on her a re-taken and after wilmits." LPN#1 was on 09/18/2014 at 12 given the resident h (Synthroid and Prilo noticed any agitation right. LPN#1 stated problems during the reported any fall or Resident #1. When of the resident's consaid, "(NA#2) reported (Resident #1) was she had blood comher left ear. I got vit blood coming out of in her face like she oxygen." When as coming from the rewould say it was like gushing but was accoming from the rewould say it was like gushing but was accoming from the rewould say it was like gushing but was accoming from the rewould say it was like gushing but was accoming from the rewould say it was like gushing but was accoming from the rewould say it was like gushing but was accoming from the rewould say it was like gushing but was accoming from the rewould say it was like gushing but was accoming from the rewould say it was like gushing but was accoming from the rewould say it was like gushing but was accoming from the reword from the reword for the reword from the rewo	sign equipment. Her pulse was as in the low 90s after getting at 2L resident's vitals were were good within normal interviewed during the survey 1:14 AM and said she had her scheduled medications usec) around 6AM and had not at that time or earlier in the did that the resident had not had agitation with regard to asked how she had learned adition that morning LPN#1 red it to me. She said slightly purple in her face and ing out of her ear. I think it was all signs right away. She had fher ear and she was purple wasn't getting enough ked about the amount of blood sident's ears LPN#1 replied, "I ee a nose bleed. It wasn't tively flowing." LPN#1 stated l#2 and #3. She indicated LPN boxygen and the resident's evel "started to come up and he back and the bleeding had haid, "I called the DON and I that was going on, - the blood, that her vital signs were okay. and left a message. The next I told her everything." When hight cause bleeding from aid, "I don't know."	F 1	157	area to an office. The resident will assessed by a license nurse and w document in the medical record. Corrective measures will be initiate immediately to protect the resident Statements will be obtained from identified employee, if any, and any possible witnesses. Employee will suspended immediately per policy pending outcome of investigation. Administrator and/or DON will com and send to RVP for prior approval then fax the 24 hour report to the NCHCPR. Notification of law enforcement if applicable. Resider interviews will be conducted by the Admissions Coordinator with alert a oriented residents and physical assessments will be conducted for non-alert and oriented residents by license nurse. At the completion or investigation the Administrator and DON will submit a 5 day report to the NCHCPR. The Administrator is responsible to direct the investigation process and to ensure that the appropriate agencies, to include the NCHCPR, are notified per policy. Current residents will be physically observed for acute changes in concatened to the completion of the co	be ill d be The plete and f the for the ne on e dition, ne ks and are that	

entered the resident's room the NAs were

the resident has been assessed, MD and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345072	B. WING			C 19/2014	
NAME OF	PROVIDER OR SUPPLIEF	₹	1	STREET ADDRESS, CITY, STATE, ZIF	•		
CAROLI	NA RIVERS NURSIN	G AND REHABILITATION CENTER	1	1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	N		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 157	changing the bed. approximately fou stated that resider Resident's lips we (LPN#1) I would gindicated that LPN #1's attending phy interviewed during PM. LPN#2 said, size of a grapefrui sheet or pillowcas little blue tinged so LPN#2 said, "Who get the doctor- that call the DON." We call the hospital to of regular office he told her to call the you that I did tell he prior occasion." LPN #3 provided a facility on 09/17/20 that when LPN#3 station, LPN#1 tol LPN#3 went into Feblood in her ear al was interviewed dat 4:15 PM. LPN#09/12/2014 she has someone paged fehall. "She (LPN#1 or anything so we that when she arri "(LPN#2) said 'The stated she went to blood in the reside she did not do an	"The ring of blood I saw was r inches in diameter. (LPN#1 ht was bleeding from her ears. The bluish tinged so I told the toxygen." The statement I#2 told LPN#1 to call Resident visician. LPN#2 was the survey on 9/19/14 at 3:50 to lid see blood, probably the transpectation of the earth of the didn't answer, I told her to the didn't answer, I told her to the hen asked if she told LPN #1 to be contact the physician outside bours, LPN#2 indicated she only doctor and added, "I can't tell her or that I didn't tell her on any awritten statement for the contact the physician outside for the contact the 200 hall nursing does not her that everything was okay. Resident #1's room and saw and on the pillowcase. LPN#3 uring the survey on 09/19/2014 as aid that on the morning of ad been giving report when for all nurses to go to the 200 didn't call any kind of a code just walked there." LPN#3 said ved at the nursing station, at's okay, we got it." LPN#3 and the resident the single the room what happened, as in the room what happened,	F 1	RP was notified timely, an given were initiated timely Acute Change in Condition Tool. This will be completed nurse, staff facilitator, and The Administrator will revinchange in Condition Monweekly for 4 weeks the memonths for accuracy and Directed inservicing to be facility licensed nurses on include change in condition resident medical treatmer will be provided in the facility qualified instructor through Carolina AHEC on October The Executive QI commit (Administrator, DON, QI, In other appropriate persons weekly x s 4 weeks and review Acute Change in Commitment of the succession of the condition of the succession of the succession of the condition of the succession o	r utilizing an n Monitoring QI ed by DON, QI d/or MDS nurses. New the Acute itoring QI Tool onthly for 3 completion. provided to all all shifts to on and getting and it. Inservicing litty by a MSN the Eastern er 15, 2014. tee MDS, and any so will meet then monthly to condition ermine trends and the monthly to defent the monthly to condition ermine trends and the monthly to defent the monthly the m		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345072	B. WING			C / 19/2014
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540		19/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	she observed fresh donut" on the linen grimacing. She said and added"I would then called the DOI back then I would hon 09/15/2014 the 09/12/2014 at appra a call from (LPN#1) #1) had some blood she didn't know what the doctor and mak (Responsible Party got to the facility (a) and I had not heard resident status until she had sent the reface and dark circle DON was interview 09/18/2014 at 5:35 call from (LPN#1) at (Resident #1) had to didn't know what to call the doctor and she did not inquire the resident's ears skin tear or scratch was anything emery doctor." The DON a resident's ears cound said, "I would he send her to the hos amount of blood I he DON said if the nur physician that the reto the hospital for each said."	ley didn't know." LPN#3 said blood, "about the size of a and the resident was d, "I didn't know what to think" have called the doctor and N and if the doctor didn't call ave called the DON again."		57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED			
		345072	B. WING			C (4.0/204.4
	PROVIDER OR SUPPLIER NA RIVERS NURSING	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540		/19/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE ACTION OF CORD OF CROSS-REFERENCED TO THE ACTION OF CROSS-REFERENCED	SHOULD BE	(X5) COMPLETION DATE
F 157	machine. Upon req physician numbers and said the off-hor doctor was not poss. LPN#4's undated s told by the off-going had been bleeding mentioned to anoth attempted to get in doctor but never tal statement also incluback of my mind I'n paged at some poir soon." The statem checked the reside and there was no a and no other symptothe resident had deeyes and there was face. "I then called see why they hadn'the rash. I spoke was about the bleeding She stated she wook Not even an hour ladark circles under his there. I called the Name and found ou said that he never of from anyone about send the resident of evaluation. Resider when she left. I was resident has sustain unaware of any recommendation.	ssage on the answering uest the DON reviewed the posted at the nursing station urs paging number for that		57		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	COM	SURVEY PLETED
		345072	B. WING _		09/1	C 19/2014
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	,	
(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 SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	was a light purple of her face and the forehead too. "I was back and I continued stated that about or checked the reside at 2L per minute. So went in to change a rash on the resident said she called the and then about an I the dark circles for called the physician went out to the hos LPN#4 said, "I thou eyes started to turn had not fallen and sand I know she did closed head injury added, "I called the (Resident #1) out." During an interview the Administrator sa have been notified sent out." During an interview Resident #1's attention stated, "I was inform been waiting for a continued known anything about bleeding from both said, "I would expension to see why	dn't see any blood but there discoloration on the right side discoloration was on her as waiting for the doctor to call and with my med-pass." LPN#4 he and a half hours later she and the oxygen was still on the said the treatment nurse a dressing and identified the atts face as petechiae. LPN#4 attending physician's nurse nour and a half later she noted ming under her eyes and a soffice again. The resident pital at approximately noon. The ught she had fallen when her black but night shift said she she was in bed all day for us in that she had fallen." She DON to tell her I was sending or that she had fallen." She DON to tell her I was sending and on 09/19/2014 at 5:15 PM, aid, "The physician should immediately and the resident and on 09/25/2014 at 9:11 AM, ding physician in the facility med that the day nurse had call back from me but I didn't at an earlier call about the ears earlier." The physician of the nurse to send her to the she was bleeding from the This (bleeding from the ears)	F 15	57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345072	B. WING			09/1) 19/2014
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	₹	STREET ADDRESS, CITY, STATE, ZIP COD 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	ÞΕ		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
F 157	The facility provided allegation of complication of complication of CREDITABLE ACOMPLIANCE F157-MD Notification. Resident # approximately 6:30 and blood coming find nurse of resident flat from resident #1 eassessed resident #3 on 9/12/14 with O2 color slightly purple went to 97%, blood rate 98. Resident #4 at approximately 7: first shift nurse with First shift nurse with First shift nurse coron 9/12/14 at 8:30 a observed. First shift rurse coron 9/12/14 aroun rash on resident face. On 9/12/14 aroun rash on resident face with first shift nurse of bleed 6:30 am, rash on face resident face. Resident face. Resident face. Resident face. Resident face. Order receive 9/12/14 approximate written to send resident resident receives 9/12/14 approximate written to send resident resident resident receives 9/12/14 approximate written to send resident resident resident receives 9/12/14 approximate written to send resident resident receives 9/12/14 approximate written to send resident resident resident receives 9/12/14 approximate written to send resident	vas notified of the Immediate on 9/18/14 at 7:41 PM. If the following credible ance on 9/19/14 at 5:00 PM. ALLEGATION OF In was observed on 9/12/14 at am by NA with flushed skin rom resident ears. NA notified ished skin and blood coming rs on 9/12/14. Nurse if at approximately 6:45 am sats range at 92% and skin. Nurse applied O2 and sats pressure 134/58 and heart if was reassessed on 9/12/14 and no active bleeding noted. In the with no active bleeding in nurse reassessed resident in and 9:30 am and observed a see and light discoloration to 1/12/14 9:30 am the MD urse was made aware by first ing from resident #1 ears at a ce, and light discoloration to 1/12/14 9:30 am and under resident 's eyes. On a urse contacted MD office nurse of darkening under resident 's eyes. On a contacted MD office nurse of darkening under resident 's eyes. On a contacted MD office nurse of darkening under resident 's eyes. On a contacted MD office nurse of darkening under resident 's eyes. On a contacted MD office nurse of darkening under resident 's eyes. On a contacted MD office nurse on ely at 11:48 am MD order was dent to ER. Hall nurse the flow of the existence of the flow of the		57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345072	B. WING				C 19/2014
	PROVIDER OR SUPPLIER	G AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
F 157	#1 during the acute suspended and dron 9/16/14. An instant and an additional in 9/16/14 with both in by 9/18/14 with all Staff Facilitator (Stassessing acute changes to interest of the physical intake to inclusive the status, behavior, in normal body systecognitive status, cloral intake to inclusive the facility is not to reach attending call the facility is not the physician of resident is conditional to the services. Acute Change in behavior and orientation, incoming in abilities change in appetite chew/swallow food	age 13 /15/14. NA assigned to resident e change in condition was ug tested by the Administrator ervice was initiated on 9/12/14 nservice was initiated on n-services completed at 100% other licensed nurses by the raff Educator) regarding nanges in condition, sending one to contact MD, examples of include abnormal bleeding, sician by telephone when an another include cognitive mune system response, in functioning, changes in manges in behavior, changes in de fluids, changes in immune in normal body functioning, alues, resident 's condition on nurse 's assessment; If reach Attending Physician, you are unable or on-call physician, you may Medical Director. Notification these types of changes in a on by fax is not acceptable. Staff for reference. No nurse work without first receiving the large is defined as anything or a resident to include but not all bleeding, skin color changes, ors, change in mental alertness creased weakness or fatigue, to feed, bathe, or groom self, alance, transfer, or walk, change in ability to la difficulty with breathing, ness change in howel	F 1	57			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345072	B. WING			C / 19/2014
	PROVIDER OR SUPPLIER	S AND REHABILITATION CENTER	8	STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	vomiting, and falls. 100% of al physically observed condition to include bleeding on 9/15/14 Staff Facilitator, Q MDS (Minimum Da consultant. Four coaudit and corrected 9/15/14 and 9/16/14 MD and RP (reside and documentation months of nurse 's ensure all documer condition to include bleeding have been interventions place notification and Resthe acute change of Facilitator nurse, Q facility consultant. during this audit wit resident by the trea concerns observed documentation in the An inservilicense nurses to in on 9/12/14, on assecondition, sending MD, notification to include second shift when an acute chaincluding abnormal status, behavior, or immune system restunctioning, Panic condition warrants	I current residents were d for acute changes in e changes in skin color and by DON Director of Nurses), (Quality Improvement) nurse, at Set) nurses (2) and facility incerns were noted during this by the treatment nurse on with interventions placed, and representative) notification, in the progress notes. Three is notes were reviewed to need acute changes in echanges in skin color and addressed with appropriate d, Attending Physician sponsible Party notification of an 9/15/14 by DON, Staff I nurse, MDS nurses (2) and Two concerns were noted the reassessment of the atment nurse on 9/16/14, no during the reassessment, and	F1	57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345072	B. WING _		05	C 9/ 19/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	7 10/2014	
CAROLII	NA RIVERS NURSING	AND REHABILITATION CENTER		1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHOOL) CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 157	you are unable to re physician, you may Director. Notificati types of changes in is not acceptable. completed on 9/18/In-service on 9/18/Facilitator regarding hospital after office after-hours number allowed to work unt MD after-hours notilicensed nurses and will be in-serviced in the physician of accondition and the a The staff not document, provide	age 15 Yeach attending or on-call call the facility's Medical on of the physician of these a resident's condition by fax This in-service was 100% 14 by Staff Facilitator. 14 was initiated by Staff g Notifying the MD through the hours and location of rs. No license nurse will be cill receiving the in-service on ification. All newly hired d newly assigned agency staff on orientation on notification to cute changes in resident fter-hours notification of MD. curse is responsible to assess, appropriate interventions and dysician and Responsible Party	F 19	57			
	9/18/14 the after-howas posted at each of the staff nurse is physician, the on-caunable to contact the nurse must call nurse will implement based on the needs Attending Physician will notify the DON changes. DON, QI MDS nurses were in Administrator on 9/ are on-call and they change in condition ask more questions picture of what is on	es in condition noted. On ours MD notification number in nurse 's station by the DON. unable to reach the attending all MD must be called. If ne attending or the on-call MD, the Medical Director. The staff of appropriate interventions of the resident and notify in and Responsible Party. Staff or on-call nurse of any acute nurse, Staff facilitator and in-serviced by the 16/14 concerning when they are receive a call concerning a in of a resident that they are to so, if needed, to get a clear occurring with the resident and jurse has notified the MD of the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345072	B. WING		C 09/19/2014	
NAME OF F	PROVIDER OR SUPPLIER	0.00.2		TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/1	3/2014
CAROLI	NA RIVERS NURSING	AND REHABILITATION CENTER	1	839 ONSLOW DRIVE EXTENSION ACKSONVILLE, NC 28540		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 157	was validated and abated at 7:35 PM staff revealed awar condition. Staff verifeceived, that chan documented in the be involved in the a should be notified a acute care as indicifing the attending or creached, the facility called. The number after regular busine nursing station. 483.13(b), 483.13(c) ABUSE/INVOLUNT The resident has the sexual, physical, arpunishment, and in the facility must not or physical abuse, involuntary seclusion. This REQUIREMED by: Based on observation interviews, interviews, interviews Services, Physician	2:10 PM the credible allegation almediate Jeopardy was when interviews with nursing reness of emergent changes in ified training had been ges in condition were to be medical record, an RN was to assessment, the physician and the resident transferred for ated. Interviews revealed that on-call physician could not be a for paging the physicians es hours was posted at the C)(1)(i) FREE FROM TARY SECLUSION The right to be free from verbal, and mental abuse, corporal voluntary seclusion.	F 157	F223-ABUSE Resident #1 was observed on 9/12		10/20/14
	of 4 residents revie combination of inju	wed for abuse was free from a ries determined to be t self-inflicted nor the result of		approximately 6:30am by CNA with flushed skin and blood coming fron resident ears. CNA notified nurse of	n	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345072	B. WING		09/1	19/2014
	PROVIDER OR SUPPLIER NA RIVERS NURSING	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 223	emergency room wand arm, had a peter swelling in her face and was showing silmmediate jeopardy the resident was for blue lips, bleeding con her face and under Jeopardy was remorped. The facility rer lower scope and se harm with potential that is not immediate completes the staff was in the process implementation of the findings included. Resident #1 was accompleted to the findings included the finding was severely MDS indicated the finding was severely mobility, had contrate extremities and cout the staff assessment indicate the predepression, mood of the staff assessment indicate the predepression.	was admitted to the with bruising on her face, neck echial rash on her face, and neck, blood in her ears igns of neck pain. It began on 09/12/2014 when and to have a purple face, but of both ears and a bruise der her eyes. Immediate boved on 09/19/2014 at 7:35 mained out of compliance at a everity of (D) isolated, no actual for more than minimal harm the jeopardy, while the facility of monitoring the their corrective action. It is distincted to the facility on a cute care hospital. Her is included multiple the weakness, anoxic brain increbral artery occlusion.	F 2	resident flushed skin and blood confrom resident #1 ears on 9/12/14. assessed resident #1 at approxim 6:45 am on 9/12/14 with O2 sats in 92% and skin color slightly purple. applied O2 and sats went to 97%, pressure 134/58 and heart rate 98. Resident #1 was reassessed on 9 at approximately 7:00 am by the three transportation of the street of the same with no active bleeding noted. First shift nurse conton to assess resident #1 on 9/12/14 and with no active bleeding observe shift nurse reassessed resident #1 9/12/14 around 9:30 am and observe shift nurse reassessed resident #2 9/12/14 around 9:30 am and observe shift nurse of bleeding from resident face. On the MD office nurse was made away first shift nurse of bleeding from resident face. Residented to resident gunder resident seyes. 9/12/14 first shift nurse contacted office nurse again and notified of darkening under resident seyes. 9/12/14 first shift nurse contacted office nurse again and notified of darkening under resident seyes. received from MD office nurse on approximately 11:00 am to send residenting the acute change was suspand drug tested by the Administrated of 9/15/14. CNA assigned to resident during the acute change in conditions suspended and drug tested by the Administrator on 9/16/14.On 9-15-worker reported to facility that hos made allegation that resident #1 his strangled. Resident #1 was alread	Nurse ately ange at Nurse blood	

PRINTED: 10/14/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
			20.22.			С	
		345072	B. WING		09/	19/2014	
NAME OF F	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
				1839 ONSLOW DRIVE EXTENSION			
CAROLI	NA RIVERS NURSIN	G AND REHABILITATION CENTER		JACKSONVILLE, NC 28540			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 223	Continued From p	age 18	F 2	23			
	of depression and ineffective coping characterized by tearfulness, anxiety and repetitive motor agitation.			hospital during the time of th Hospital reported allegation of strangulation to the local law which came to the facility to	of enforcement		
	reviewed for the educated 09/12/2014 resident was in be	Resident #1's record was vents on 09/12/2014. An entry at 12:15 AM, indicated the d with her eyes closed, that she		9/15/14. 24 hour report for a abuse/suspicion of crime wa and faxed to the NC Health (Personnel Registry 9-16-14)	illegation of s completed Care by the		
	repositioning. The	nd required staff turning and entry stated there were no signs of distress. The note was		Administrator. The investiga injury of unknown origin and initiated by the Administrator and completed on 9/18/14. report was completed and fa	abuse was on 9/15/14 The 5 day		
	and read, "CNA (N that resident was I	s dated 09/12/2014 at 6:51 AM Jursing Assistant) informed me bleeding out of her ears.		NCHCPR on 9/18/14.			
	her face was sligh stated the Resider sat) was 92%. Afte oxygen the O2 sat	d coming out of her ears and tly purple." The note also nt's oxygen saturation level (O2 er the resident was given was 97%, the blood pressure eart rate was 98. The note		The facility Admission □s Codinitiated abuse interviews for oriented residents. There we and oriented residents interviews questions regarding: Do they the facility? Has anyone con	all alert and re 29 alert iewed with r feel safe in		
	informed, a voicer the attending phys to contact the resp	ctor of Nursing (DON) was nail message had been left for sician and the nurse was unable consible party (RP). The note ensed Practical Nurse (LPN)#1.		room, visitor or another residence made them feel uncomfortal anyone physically or verbally them? On 9-15-2014. Additional interviews were conducted on the conducted of the con	ole? Has harmed onal n 9/18/14,		
	11:48 AM stated R	chone order, dated 9/12/2014 at Resident #1 was to be sent to gency room for evaluation.		9/20/14, 9/21/14, 9/22/14, 9/ 9/24/14. No concerns voiced interviewed. All other reside unable to communicate or w disoriented were assessed by	d by residents nts who are ho are		
	read, "Resident be shift. No Bleeding to upper face and noted. Resident co NC (nasal cannula	2/12/2014 the progress note eing assessed throughout the noted thus far, but a rashy area dark circles to Bilat (both) eyes ontinues on 2L (2 liters) O2 via a). Resident grimacing more hysician) made aware. No		nurse, MDS nurses, and state any bodily signs of abuse on bodily signs of abuse or injur origin. An additional skin assall current residents was con 9/22/14 by the DON, QI nurses Facilitator, and the MDS nurses.	f facilitator for 9/15/14. No y of unknown sessment on ducted on e, Staff		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345072	B. WING			C 19/2014	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	•	19/2014	
TW TWIL OT	NOVIDEN ON OUT FIELD	`		1839 ONSLOW DRIVE EXTENSION			
CAROLII	NA RIVERS NURSIN	G AND REHABILITATION CENTER	2	JACKSONVILLE, NC 28540	IN .		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 223	answer at RP's nu note was signed by A progress note daread, "Resident be shift. No bleeding to upper face and Upon starting shift around eyes appet throughout the shi via NC. Resident of made aware. No a made aware. The Review of an amb Care Report" inclusted in high patients of the bound in bed in nu observed to be gut two black eyes, nu how she got the blood from the the hospital at 12:: The hospital Emer dated 09/12/2014 petecchiae to face blood from ears. The patient's throat the prints. I am conce attempted strangur (Department of Scadmit patient for high patient for high patient for high patient for high patient and the prints. I ask her if a strangur of the same patient for high patien	mber. DON made aware." This y LPN#2. ated 09/12/2014 at 12:15 PM eing assessed throughout the noted thus far, but a rashy area dark circles to Bilat eyes noted. In o black circle noted. Area ared to slowly darken ft. Resident continues on 2L O2 grimacing more than usual. MD answer at RP's number. DON to enote was signed by LPN#2 ulance transportation "Patient uded, "Chief Complaint: Primary Symptom: Pain. Patient uded, "Chief Complaint: Primary Symptom: Pain. Patient resing home, pt (patient) was arding her abdomen and had urse stated she did not know lack eyes and that they were by." The transport note	F 2	concerns were noted. The procedure for all alleg and injury of unknown orig Any employee accused of immediately removed from area to an office. The resussessed by a license nur document in the medical responsible witnesses. Employee, if any possible witnesses. Employees witnesses. Employees witnesses. Employees witnesses. Employees and to RVP for prior then fax the 24 hour report NCHCPR. Notification of enforcement if applicable. Interviews will be conducted Admissions Coordinator woriented residents and phy assessments will be conducted and oriented residents and phy assessments will be conducted and oriented residents and phy assessments will be conducted and oriented residents and phy assessments will be conducted and oriented residents and oriented residense nurse. At the cominvestigation the Administra responsible to direct the in process and to ensure that appropriate agencies, to in NCHCPR, are notified per An Action Checklist was in 9/19/14 for License nursin placed at each nurse □s st	gin is as follows: a abuse will be n resident care ident will be se and will ecord. be initiated resident. ed from y, and any oyee will be er policy tigation. The l will complete approval and t to the law Resident ed by the yith alert and ysical ucted for idents by upletion of the rator and/or the eport to the lator is nvestigation at the nclude the repolicy. initiated on the staff and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345072	B. WING		O9/19	9/2014
	PROVIDER OR SUPPLIER	S AND REHABILITATION CENTER	, 1	TREET ADDRESS, CITY, STATE, ZIP CODE 839 ONSLOW DRIVE EXTENSION ACKSONVILLE, NC 28540	, , , , , ,	
(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) COMPLETION DATE
F 223	revealed the Compscan was negative was no mass or he significant findings During an interview Hospital Physician regarding her exarafternoon of 09/12 said that in addition eyes and on her nebruise on her upper emergency depart #1 said, "We had to times to get the list that Resident #1 would have caused Hospital Physician cause that petechi distinctive, pathogocharacteristic of a a sign or symptom made]." The physpetechial rash is in crushing force. I cowould have caused The documentation hospital physician 09/12/2014 include atraumatic except ecchymosis (bruisi eyes). Patient has a lip up to the forehe indicated there wa "on the left side of	ort (dated 09/12/2014) outerized Tomography (CT) for a cranial fracture, there ematoma and no other	F 223	allegations of abuse and injury of unknown origin. The Action Check includes: "Remover involved employee, if known, from resident care area to office: instruct employee to wait in until your return "Notify Administrator and/or DO immediately of incident "Assess resident: document notification in chart "Notify attending MD; document notification in chart "Implement MD orders as indica "Notify resident □s representative indicated; document notification in "Obtain employee witness state incident "Drug test employee per persor policy as applicable or as instructed Administrator or DON "Punch employee out and send immediately pending outcome of investigation "Implement corrective measure protect resident (i.e., alarm braceled padding of equipment, 1:1 monitorietc.) "Completion of Resident QI Regform (electronic QI incident record) "Continue to monitor resident as appropriate All license nurses to include LPN ##2, LPN #3, and LPN #4 were in-secon the Action Checklist that has be placed at all nurses□ station, initiating 9/19/14 by the Staff facilitator and we completed 100% on 9/23/14.	f an office N t ated ve as chart ement of home s to et, ing, corting) s erviced en ted	

PRINTED: 10/14/2014 FORM APPROVED OMB NO. 0938-0391

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			7 BOILD!		С		
		345072	B. WING		09/	19/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CAROLI	IA RIVERS NURSING	AND REHABILITATION CENTER		1839 ONSLOW DRIVE EXTENSION			
OAROLII	TA KIVEKO NOKOMO	AND REHADIEHATION GENTER		JACKSONVILLE, NC 28540			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRICE OF THE AP	LD BE	(X5) COMPLETION DATE	
F 223	home staff and they what happened. Patotally bedridden so This has to be invecalled." Hospital Physician 09/18/2014 at 10:4 has so many unexplife-threatening injupossible causes for Hospital Physician the ears was usual fracture or very forestated that petechia strangulation or for nursing home had Hospital Physician cranial fracture but tissue in her face a subconjuctival hem #2 said, "I don't knocause all of that othyou rule out a fall, whospital Physician #2 indicated with the facility she had not shared any Hospital Physician still in the hospital. On 9/17/2014 at 5:0 Social Services (Donospital had called message after hour allegations of abus Social Worker also	se? We spoke with the nursing y truly do not have any idea of atient is not ambulatory. She is there was no history of a fall. Stigated and DSS will be #2 was interviewed on 4 AM and said, "This patient blained injuries. These were ries." When asked about the bleeding from the ears, #2 stated that bleeding from ly associated with a skull beful coughing. She further are is often found with ceful vomiting and that the said there was no vomiting. #2 said that tests showed no there was swelling of the soft and neck, bruising, and corrhaging. Hospital Physician ow of anything that could ner than strangulation when comiting or forceful cough." Ited that during communication had only asked questions and concerns with facility staff. #2 indicated Resident #1 was possible production. The said this resident "didn't have said this resident "didn't have	F 2	"The staff nurse is responsible assess, document, provide approinterventions and notify Attending Physician and Responsible Party acute changes in condition noted 9/18/14 the after-hours MD notifinumber was posted at each nurse station by the DON. If the staff nunable to reach the attending phene the on-call MD must be called. If contact the attending or the on-call murse must call the Medical Interventions based on the needs resident and notify Attending Phyand Responsible Party. Staff will the DON or on-call nurse of any changes. DON, QI nurse, Staff from and MDS nurses were in-service Administrator on 9/16/14 concerning a change in condition resident that they are to ask mor questions, if needed, to get a cle of what is occurring with the resident that the nurse has notified MD of the acute change. The DON will determine if the acchange in condition reported by the nurse fits the definition of an injury of any type occurs where the cause or contribution of an injury of unknown then the abuse/injury of un	of any of a		
	much family contac	t."		procedure will be followed to incl employee accused of abuse will			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDING			С	
		345072	B. WING			19/2014	
NAME OF F	PROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP CODE			
				1839 ONSLOW DRIVE EXTENSION			
CAROLII	NA RIVERS NURSIN	G AND REHABILITATION CENTER		JACKSONVILLE, NC 28540			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	TION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE ROPRIATE	COMPLETION DATE	
F 223	Continued From p	age 22	f 2:	23			
	•	1:47 AM, the Police Detective		immediately removed from resi	dent care		
		tified by the hospital on Monday		area to an office. The resident			
		he allegation of strangulation.		assessed by a license nurse ar			
	o, . o. <u>_</u> o , a. o a			document in the medical record			
	The facility provide	ed their investigation and written		Corrective measures will be ini	iated		
	statements from the	ne facility staff taken on		immediately to protect the resid	ent.		
		h 09/17/2014. After review of		Statements will be obtained fro	n		
		ment, the facility staff were		identified employee, if any, and			
	interviewed during	the survey.		possible witnesses. Employee			
	O = 00/40/004 4 N			suspended immediately per po			
		rrsing Assistant (NA) #1 wrote, I no falls on 11-7 that I'm aware		pending outcome of investigation			
	,	s (weeks)." An interview was		Administrator and/or DON will of and send to RVP for prior appropriate to the send to RVP for prior appropriate to the send to RVP for prior appropriate to the send to the se			
		A #1 on 09/18/2014 at 10:42		then fax the 24 hour report to the			
		ed she was working the 11 PM		NCHCPR. Notification of law	C		
		provided care for Resident #1,		enforcement if applicable. Res	dent		
		on who discovered Resident #1		interviews will be conducted by			
		. NA#1 stated that the resident		Admissions Coordinator with a			
		and when agitated, would pull		oriented residents and physical			
		and incontinent brief. NA #1		assessments will be conducted			
		night the resident had been		non-alert and oriented resident			
		ng her brief. At approximately		license nurse. At the completion			
		oked in to check on the		investigation the Administrator			
		ther with the gown pulled up		DON will submit a 5 day report	to the		
		#1 said Resident #1 was facing her right side and her sheet		NCHCPR. The Administrator is	action		
		NA#1 saw blood on sheet, and		responsible to direct the investi process and to ensure that the	jalion		
		se together on the pillow in		appropriate agencies, to includ	the		
		"I had no idea where the blood		NCHCPR, are notified per police			
		so I went to look." NA #1		The state of the s	, -		
		t on her back, "and the blood					
		(left) ear" so she turned her on		The Staff Facilitator initiated in	servicing		
		to look for the nurse. NA#1		for all staff on 9/15/14 to includ	e dietary,		
	•	er of the nurses were available		laundry, housekeeping, AR boo			
		e 100 hall was doing care and		payroll, medical records, maint			
		ner to come with her to		activities, therapy, admission c			
		n. NA#1 and NA#2 went back		CNAs to include NA #1 and NA			
		hen NA#2 saw the resident she		license nurses LPN #1, LPN #2			
	Liett to ao aet LPN#	#1. NA#1 stated that when she		and LPN #4 on abuse and was	completed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY PLETED
		, 50.25.		- (С
	345072	B. WING			19/2014
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLINA RIVERS NURSING	AND REHABILITATION CENTER		1839 ONSLOW DRIVE EXTENSION		
			JACKSONVILLE, NC 28540		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		LD BE	(X5) COMPLETION DATE
over blood came ou "The nurse sometin to get her to calm. E all night long, restle not reported the resonurse. Nursing Assistant (I included, "I got dorand as I was makin station I bumped in #1) was bleeding. A that her face was blood in her ears." that the resident waleft to find nurse #1 resident's vital signs during the survey, csaid, "I was through (NA#2) was coming (Resident #1) was kny or where. So I (Resident #1's) face bleeding." NA#2 sa and she told me to On 09/15/2014 LPN of 6:30-6:45ish am, (Resident #1) had be and was slightly pur room with my vital shigh and her O2 was oxygen put on her a re-taken and after vilimits." LPN#1 was survey, on 09/18/20	sident #1 up and turned her ut of the other ear. NA#1 said, nes has to give her medication But not that night, she was up iss." NA#1 said that she had sident's restlessness to the NA) #2's undated statement ne caring for my residence(sic) ig my way to the back nurses to (NA#1) who said (Resident as I enter the room I noticed lue and that their (sic) was NA#2's statement included as scratching her face. NA#2 who told her to get the s. NA#2 was interviewed on 9/18/2014 at 5:20 PM and in with my rounds and saw gout of her room and she said oleeding and she didn't know followed into the room and her e was blue and we noticed her aid, "I left to go find a nurse	F 2	· · · · · · · · · · · · · · · · · · ·	or abuse, ins are ne se, must ged will then trator concern iplinary f naviors to lling, or swhile sed of ons of ided ending All staff, dietary, ords, nurses e is, ways bserve a ated is was ees will icy and	

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						С		
		345072	B. WING				09/19/2014	
NAME OF PROVIDER CAROLINA RIVE		AND REHABILITATION CENTER		18	FREET ADDRESS, CITY, STATE, ZIP CODE 339 ONSLOW DRIVE EXTENSION ACKSONVILLE, NC 28540			
	CH DEFICIENC	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
noticed night. L probler reporter Reside of the reside of the reside of the reside she had her left blood of in her feat oxygen coming would see gushing that she were color see stopped resider she the idea." her ever purple I called nurse of asked a both early changing approxes stated for the state of the color see color see stopped in the see color see see see she the idea." On 09/LPN#1 entered changing approxes stated for the see see see see see see see see see s	PN#1 stated in s during the dany fall or int #1. When esident's co (NA#2) reported #1) was depended by the fact of the fact of the doctor and the doctor and the doctor and the doctor and the fact of the resident for the fact of the resident for the fact of t	inge 24 In at that time or earlier in the dight that the resident had not had a night and no one had agitation with regard to asked how she had learned indition that morning LPN#1 red it to me. She said slightly purple in her face and ing out of her ear. I think it was all signs right away. She had if her ear and she was purple wasn't getting enough ked about the amount of blood sident's ears LPN#1 replied, "I e a nose bleed. It wasn't stively flowing." LPN#1 stated l#2 and #3. She indicated LPN oxygen and the resident's evel "started to come up and he back and the bleeding had stated there were no other lways and when asked what curred she stated, "I have no "I called the DON and I told was going on, - the blood, that her vital signs were okay, and left a message. The next I told her everything." When might cause bleeding from haid, "I don't know." N#2's statement included that or assistance and when she at's room the NAs were "The ring of blood I saw was inches in diameter. (LPN#1) was bleeding from her ears. It bluish tinged so I told	F 2	2223	during orientation by the Staff Facil All potential employees will be scre by the facility for abuse by the Staff Facilitator prior to employment. The screening process will include the requesting of information from prevand/or current employers i.e. refere checks, checking with the approprialicense board and/or registries, and completion of criminal background. Any employee found to have an alle of abuse against them will not be of employment. Abuse quizzes were initiated on 9/1 with all staff to include dietary, laun housekeeping, AR book keeper, pare medical records, maintenance, activate therapy, admission coordinator, CN include NA#1 and NA#2, and licer nurses LPN#1, LPN#2, LPN#3, a LPN#4 by the Staff facilitator to vastaff knowledge of abuse and was completed by 100% of staff on 9/22. These questions include; who shour eport abuse to? When should you abuse? Give 2 examples of abuse What is the first thing you do if you hear a resident being abused from member or visitor? 100% validation completed with all staff. Any staff member unable to answer any que accurately on the quiz will be immere-trained and tested again by the Stacilitator. Staff who are unable to correctly answer the questions on tafter two attempts will be removed working with residents until they are working with residents until they are working with residents until they are	ened is vious ence ate I check. egation ffered I7/14 dry, ayroll, vities, IAs to ase and lidate I/14. Ild you a report is see or a staff a was stions diately Staff he quiz from		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345072	B. WING		C 09/19/2014
NAME OF F	PROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2011
CAROLI	NA RIVERS NURSIN	G AND REHABILITATION CENTER	!	839 ONSLOW DRIVE EXTENSION IACKSONVILLE, NC 28540	
040.15	CLIMMA DV CT	TATEMENT OF DEFICIENCIES	1	·	J 0/5
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 223	Continued From p	age 25	F 223		
	indicated that LPN #1's attending phy on 9/19/14 at 3:50 blood, probably the 3-4 inches on the resident's lips were get some oxygen. not do an assessm LPN#1 applied the When asked about from both ears LP me she couldn't ge answer, I told her if she told LPN #1 the physician outs indicated she only	et oxygen." The statement 1#2 told LPN#1 to call Resident sician. LPN#2 was interviewed PM. LPN#2 said, "I did see e size of a grapefruit, maybe sheet or pillowcase. The e a little blue tinged so I went to "LPN#2 stated she herself did nent of Resident#1 and that e oxygen and took vital signs. It what might cause bleeding N#2 said, "When (LPN#1) told et the doctor- that he didn't to call the DON." When asked to call the hospital to contact ide regular office hours, LPN#2 told her to call the doctor and you that I did tell her or that I ny prior occasion."		to validate knowledge. Staff member unable to validate knowledge will not allowed to work in this facility. The Staff Facilitator will continue at in-services for all staff monthly for fronths and all new orientees hired receive this training before working residents. Staff to resident interactions were in on 9/17/14 by Facility Consultant observing how staff to include housekeeping, therapy, dietary, nur include NA #1, NA #2, LPN #1, LPN LPN #3, and LPN #4, interact with residents and for sign and sympton abuse. These staff to resident interwere completed with 100% of all employees, on all shifts, to insure	ot be Duse Tour Will With Initiated Tring to N #2, or the of raction
	facility on 09/17/20 that when LPN#3 station, LPN#1 told LPN#3 went into F blood in her ear ar was interviewed duat 4:15 PM. LPN#3 09/12/2014 she has someone paged for hall. "She (LPN#1) or anything so we that when she arri" (LPN#2) said 'That stated she went to blood in the reside she did not do an but did ask the NA	a written statement for the 014. The statement included arrived at the 200 hall nursing d her that everything was okay. Resident #1's room and saw and on the pillowcase. LPN#3 uring the survey on 09/19/2014 as said that on the morning of ad been giving report when or all nurses to go to the 200 didn't call any kind of a code just walked there." LPN#3 said wed at the nursing station, at's okay, we got it."" LPN#3 a Resident #1's room and saw ent's right ear. LPN## stated asssessment of the resident as in the room what happened, they didn't know." LPN#3 said		appropriate interaction with the resi on 9/27/14. The abuse policy will be initiated for any employee found to inappropriate with a resident to include but not limited to, removal of the employee from the resident, susperinvestigation, notification to the appropriate State agency, disciplinated action up to termination. The Administrator coordinated with Sheriff Department and the City Poprovide off duty police officer will proprior as wift monitoring in facility for suspicious activity from 9/23/14 to 10/07/2014. A schedule for department managers, Dietary manger, dietary assistant manager, activity director assistant activity director, payroll, sclerk, medical records. Administrate	the lice to ovide ment

PRINTED: 10/14/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345072	B. WING		09/1	C 19/2014
	PROVIDER OR SUPPLIER	S AND REHABILITATION CENTER	1	TREET ADDRESS, CITY, STATE, ZIP CODE 839 ONSLOW DRIVE EXTENSION ACKSONVILLE, NC 28540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) BY PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 223	she observed fresh donut" on the linen grimacing. She sai and added"I would then called the DO back then I would I On 09/15/2014 the 09/12/2014 at appra call from (LPN#1 #1) had some blooshe didn't know whithe doctor and mal (Responsible Partygot to the facility (a and I had not heard resident status untishe had sent the reface and dark circle DON was interview 09/18/2014 at 5:35 call from (LPN#1) a (Resident #1) had didn't know what to call the doctor and that she did not incom the resident's was a skin tear or sthink it was anythin call the doctor." The been more inquisit to the day shift nurthe bleeding from the DON did not go to resident herself. The blood from a resident herself. The blood from a resident herself. The blood from a resident herself injury and sail	age 26 In blood, "about the size of a and the resident was d, "I didn't know what to think" have called the doctor and N and if the doctor didn't call have called the DON again." DON wrote that on roximately 6:50 AM, "I received). She stated that (Resident d coming out of her ears and lat to do. I said you need to call ke sure to call the R.P. (a) as well. She stated okay. I pproximately) 8:30 on 9/12/14 d anything else regarding if 7-3 nurse (LPN#4) stated that resident to the ER for rash on the else of the else o	F 223	DON, QI nurse, Staff facilitator and nurses (2) to observe residents aft hours of 5pm to include 3rd shift w initiated 9/19/14, 7 days per week to include nights and week-ends. The department managers will use a chand observe all residents for: Does resident seem fearful (flinching, gut tearful)? Are there any visible bruise edema, red areas to include the farneck? Staff interactions with reside signs and symptoms of abuse. If red be any concerns during the observe Dietary manger, dietary assistant manager, activity director, payroll, supply cler medical records, Administrator, Donurse, Staff facilitator or MDS nurse will immediately contact the hall nut the Administrator. Resident abuse interviews will be conducted by the Admissions Coor and/or Social Worker with question regarding residents understanding abuse and if this has occurred to the resident. These interviews will occur weekly X s4 weeks, then monthly months utilizing a QI tool. Current residents will be physically observed any bodily injury of abuse or any of unknown injury using census as documentation, Monday-Friday X weeks, then weekly X s 4 weeks at then monthly X s 3 months and an concerns immediately reported to the Administrator and DON to insure a identified abuse allegations and Injection of the provided to the Administrator and DON to insure a identified abuse allegations and Injection of the provided to the Administrator and DON to insure a identified abuse allegations and Injection of the provided to the Administrator and DON to insure a identified abuse allegations and Injection of the provided to the Administrator and DON to insure a identified abuse allegations and Injection of the provided to the Administrator and DON to insure a identified abuse allegations and Injection of the provided to the Administrator and DON to insure a identified abuse allegations and Injection of the provided to the Administrator and DON to insure a identified abuse allegations and Injection of the provided to the provision of the provided to the provision	er the as to enecklist is the arding, sing, ince and ents for noted to rations, in the control of the cur ince and ents ardinator in the cur ince and ents are the cur ince and ents	

PRINTED: 10/14/2014 FORM APPROVED OMB NO. 0938-0391

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345072	B. WING			C 19/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	10/2011	
CAROLII	NA RIVERS NURSING	G AND REHABILITATION CENTER		1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 223	The DON said if the the physician that is sent to the hospital she learned that LI physician's office a answering machine reviewed the physician's office a answering station and number for that do desk. The DON als Registered Nurses morning of 09/12/2 #1. LPN#4's undated stold by the off-goin been bleeding from mentioned to anoth attempted to get in doctor but never tastatement also incompassed at some poisoon." The statem checked the reside and there was no a and no other sympthe resident had deeyes and there was face. "I then called to see why they had about the rash. I stold her about the las well. She stated call back. Not ever to have dark circle pooled there. I call them know and for	age 27 the nurse did not hear back from the resident should have been I for evaluation. The DON said PN#1 had called the and left a message on the e. Upon request the DON ician numbers posted at the disaid the off-hours paging actor was not posted at the so indicated that none of the so indicated that none of the in the building on that Friday 2014, had assessed Resident statement indicated she was ginurse that Resident #1 had in her ears. "The nurse her that it was a lot. She in touch with the resident's alked to him." LPN#4's lluded, "All the while in the imit thinking her doctor was int and he should be calling then indicated LPN#4 had ent at approximately 8:30 AM active bleeding from the ears of the MD's (physician's) office and the MD's (physician's) office and the discoloration on her did the MD's (physician's) office and to tell them poke with the MD's nurse and bleeding from the previous shift of she would let him know and in an hour later resident began is under her eyes like blood had ed the MD's office back to let and out from the nurse that the lever received any pages or	F 2	investigated per policy and sethe NCHCPR. This will be component to DON, QI nurse, staff facilitated MDS nurses. The Administrate review the resident abuse in physical assessment weekly weeks, then monthly X sometimes of a seem of a seem of the rapy, dietary, nursing to in NA #2, LPN #1, LPN #2, LPI LPN #4 to ensure staff know policy and procedure of abuse for all staff daily with 10 intenshift, 6 interviews on 3-11 shinterviews on 11-7 shift weel weeks and then monthly X utilizing a QI tool. The Adminate review the abuse quizzes we weeks, then monthly X sometimes and any concern staff interactions will occur of acility staff on all 3 shifts to #1, NA #2, LPN #1, LPN #2, LPN #4, 10 interactions on 7 interactions on 3-11 shift, 4 in 11-7 shift, X sometimes 4 weeks, then monthly X sutilizing a QI tool to docume resident interactions. The A will review the staff interactions of the staff inte	completed by tor, and/or rator will sterviews and y X s 4 months for as. Leted by all ekeeping, anclude NA #1, N #3, and wledge on the se, will occurriews on 7-3 and and 4 kly X s 4 s 3 months for as. Leted by all ekeeping, and wledge on the se, will occurriews on 7-3 and 4 kly X s 4 s 3 months for as. Leted by all ekeeping, and wledge on the se, will occurriews on 7-3 and 4 kly X s 4 s 3 months for as. Letel by all ekeeping, and wledge on the sekely X s 4 s 3 months for a sekely X s 3 months and the staff to deministrator ons weekly X s 3 months cerns. Conitor facility ctivity X 2 are		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 t. BOILBII			С	
		345072	B. WING _		09/	19/2014	
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
CAROLINA	A RIVERS NURSING	AND REHABILITATION CENTER		1839 ONSLOW DRIVE EXTENSION			
OAROLINA	TRIVERO NOROINO	AND REHABILITATION CENTER		JACKSONVILLE, NC 28540			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	nstructed to send to revaluation. Resigned has sustain unaware of any reconterviewed during a 10:08 AM. She state and the forehead too. "I was back and I continue stated that about on the checked the resident at 2L per minute. So went in to change at 2L per minute. So went in to change at a 2L per minute. So went in to cha	about the matter. I was he resident out to the hospital dent was alert with eyes open is asked by MD's office if ned any falls but I was	F 22	police officer round sheets we weeks. Department managers will obtoe resident after the hours of 5pt 3rd shift per schedule utilizing document observation daily X then weekly X sheeks, the X sheeks of 3 months. The Administration review the department manages hours observations weekly X then monthly X sheeps 3 months from the Executive QI committee, but not limited to, the Facility Director, Administrator, DON, nurse will meet weekly X sheeps 4 monthly to review resident about interviews, audits for bodily in quizzes, staff to resident interduty police officer round sheeps department managers after hobservations to determine an and/or trends and the need for monitoring and the frequency	serve m, to include g a QI tool to S 4 weeks, en monthly eator will gers after s 4 weeks, or to include, Medical and QI and then use jury, Abuse actions, off its, and ours y issues or continued		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		345072	B. WING			09/	19/2014
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		183	REET ADDRESS, CITY, STATE, ZIP CODE 99 ONSLOW DRIVE EXTENSION CKSONVILLE, NC 28540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	ears " The Administ question was if she head. When I was to discoloration I thouse condition going on a said, "My initial tho that someone harm clinically. I never the She added, "I had investigation of injurasked if a Registere Resident #1 on 09/said, "Not to my knowld expect an Rhavailable, the Adminhave expected the nurse came in and coming out of her eto send her out." If she was informed a on Monday, 09/15/2 investigation at that During an interview the Administrator said, recognize an injury them to tell me aboinjury so myself and determination."	at the blood out of one of her strator also said, "My first had a recent fall or struck her told about the rash and ght there was an acute after ruling out a fall." She bught (on 09/12/2014) was not need her but what was going on ought that someone hurt her." no reason to initiate ary of unknown origin." When he had have expected her out. If the found her blue with blood hars I would have expected her the Administrator indicated about the allegation of abuse 2014 and initiated an	F 2	223			

· · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		345072	B. WING			C 09/19/2014	
	PROVIDER OR SUPPLIER	S AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540		10,2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE	
F 223	know anything about bleeding from both stated the resident that would cause by petechiae. The physthe nurse to send his she was bleeding from emergency." The Administrator of Jeopardy for F309 The facility provider allegation of complement of complement for the facility provider allegation of resident flow from resident #1 eassessed resident for 12/14 with O2 color slightly purplement to 97%, blood rate 98. Resident facility approximately 7: first shift nurse with First shift nurse with First shift nurse coron 9/12/14 at 8:30 and sobserved. First shift #1 on 9/12/14 arour rash on resident facility facility facility facility for the facility facility for the f	age 30 call back from me but I didn't ut an earlier call about the ears earlier." The physician was not on any medications leeding from the ears or sician said, "I would expect er to the hospital to see why rom the ears." He added, in the ears) was definitely an was notified of the Immediate on 9/18/14 at 7:41 PM. If the following credible iance on 9/19/14 at 5:00 PM. ATION OF COMPLIANCE Deserved on 9/12/14 at am by NA with flushed skin from resident ears. NA notified ushed skin and blood coming ers on 9/12/14. Nurse #1 at approximately 6:45 am sats range at 92% and skin and should be not earlier than the same of the same sats and heart pressure 134/58 and	F 2	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345072	B. WING			19/2014
	NAME OF PROVIDER OR SUPPLIER CAROLINA RIVERS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	, ,	
(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 APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 223	was made aware to from resident #1 eand light discolorat #1 was assessed to approximately 10:3 under resident's eycontacted MD office darkening under refrom MD office nur 11:00 am to send reassigned to reside was suspended and Administrator on 9. #1 during the acute suspended and dron 9/16/14. On 9-1 facility that hospital was pended and dron 9/16/14. On 9-1 facility that hospital during the hospital du	by first shift nurse of bleeding ars at 6:30am, rash on face, arion to resident face. Resident by first shift nurse again at 80 am an observed darkening ares. On 9/12/14 first shift nurse are nurse again and notified of a sident's eyes. Order received are on 9/12/14 approximately aresident to ER. Hall nurse and the during the acute change and drug tested by the area of the Administrator of 5-14 APS worker reported to a made allegation that resident agled. Resident #1 was already and the time of the allegation. Allegation of strangulation to the ant which came to the facility and the NC Health Care are always of the injury of dabuse was initiated by the are port was completed and	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345072	B. WING				C 19/2014
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
F 223	interviewed. All oth communicate or whassessed by DON, nurse, MDS nurses bodily signs of abus of abuse or injury of abuse or injury of were noted. The procedure for a injury of unknown of employee accused removed from resident will be and will document of the resident will be and will document of the resident will be and will document of the resident interviewed by the point of the possible witnesses immediately per point of law of the fax the 24 hou. Notification of law of Resident interviewed Admissions Coording residents and physiconducted for nonlicense nurse. At the investigation the Administrator is resinvestigation proce appropriate agencing are notified per policensed nursing sidents.	incerns voiced by residents are residents who are unable to no are disoriented were QI (Quality Improvement) and staff facilitator for any se on 9/15/14. No bodily signs of unknown origin. No concerns all allegations of abuse and origin is as follows: Any of abuse will be immediately dent care area to an office. It is assessed by a license nurse in the medical record. It is will be initiated immediately ent. Statements will be suspended alicy pending outcome of administrator and/or DON will to RVP for prior approval and are report to the NCHCPR. It is will be conducted by the nator with alert and oriented ical assessments will be alert and oriented residents by the completion of the diministrator and/or the DON report to the NCHCPR. The sponsible to direct the ses and to ensure that the es, to include the NCHCPR, icy.	F 2	223			
	Licensed nursing s						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345072	B. WING		C 09/19/2014		
	PROVIDER OR SUPPLIER	G AND REHABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLET		
F 223	The Action Checkl Remove in from resident care employee to wait in Notify Adnimmediately of incomplements of the Notify attention of the Notify attention of the Notify resimplements of the Notify resident (i. equipment, 1:1 more completion of the Notify attention of the Notify of the Notify Attending Profit of any acute changes of the Notify Attending Profit of any acute changes of the Notify Attending Profit of the Notify Att	se and injury of unknown origin. ist includes: nvolved employee, if known, area to an office: instruct in office until your return ininistrator and/or DON ident sident: document notification in inding MD; document to the MD orders as indicated dent's representative as intentification in chart inployee "witness" statement of employee per personnel policy is instructed by Administrator or inployee out and send home ing outcome of investigation to to corrective measures to e., alarm bracelet, padding of onitoring, etc.) in of Resident QI Reporting	F 223				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345072	B. WING			C / 19/2014	
NAME OF I	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		710/2014	
CAROLII	NA RIVERS NURSING	S AND REHABILITATION CENTER		1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540			
(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 CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 223	was posted at each of the staff nurse is physician, the oncounable to contact the nurse must cal nurse will impleme based on the need Attending Physicia will notify the DON changes. DON, Q MDS nurses were Administrator on 9 are on-call and the change in condition ask more question picture of what is on to insure that the nacute change. A G will be used daily be Administrator will remain the DON will determine the definition of an injury any type that occur contributing factor of the acute change of an injury of unknown the definition of an injury of unknown	n nurse's station by the DON. unable to reach the attending all MD must be called. If he attending or the on-call MD, I the Medical Director. The staff int appropriate interventions is of the resident and notify in and Responsible Party. Staff or on-call nurse of any acute I nurse, Staff facilitator and in-serviced by the I 16/14 concerning when they by receive a call concerning a in of a resident that they are to is, if needed, to get a clear ccurring with the resident and urse has notified the MD of the I tool, Acute Change Call Log, by the On-Call nurse and the	F 2	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345072	B. WING			19/2014
	PROVIDER OR SUPPLIER	S AND REHABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	1 00/	10/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 223	approval and then NCHCPR. Notifica applicable. Reside by the Admissions oriented residents be conducted for residents and submit a 5 day Administrator is resinvestigation process appropriate agence are notified per poor The Staff Facilitate staff on 9/15/14 to housekeeping, AR records, maintenated admission coording on abuse. The abualleged violations is or abuse, including are reported as so Administrator, any abuse or suspects immediately report supervisor, who with Administrator and/concern related to action and possible facility will provide behaviors to include derogatory language communicating with and employees actin allegations of at suspended immediately remediately immediately responsible facility will provide behaviors to include a multiple and employees actin allegations of at suspended immediately remediately responsible facility will provide behaviors to include a multiple and employees actin allegations of at suspended immediately responsible facility will provide behaviors to include a multiple and employees actin allegations of at suspended immediately responsible facility will provide behaviors to include a multiple and employees actin allegations of at suspended immediately responsible facility will provide behaviors to include a multiple facility wil	ole Vice President) for prior fax the 24 hour report to the ation of law enforcement if ent interviews will be conducted Coordinator with alert and and physical assessments will con-alert and oriented residents At the completion of the dministrator and/or the DON report to the NCHCPR. The sponsible to direct the less and to ensure that the less, to include the NCHCPR,	F 223			

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		CON	(X3) DATE SURVEY COMPLETED		
		345072	B. WING			C / 19/2014
	PROVIDER OR SUPPLIER	S AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 223	the in-service that on 9/19/14. All stal laundry, dietary, m receptionist, payro therapy, admission license nurses was definition and signs prevent and what too-worker with Bur Staff Facilitator. N work until receiving Upon hire all newly and receive the abin-service and validating an assignm Staff Facilitator. A screened by the far Facilitator prior to process will include from previous and reference checks, license board and/criminal backgrour to have an allegatinot be offered emp. Abuse quizzes were Staff facilitator to value. These queereport abuse to? A Give 2 examples of thing you do if you abused from a star validation will compstaff member unablaccurately on the control of the staff member unablaccurat	racation that has not received will be mailed a certified letter ff, to include housekeeping, aintenance, AR book keeper, II, medical records, activities, as coordinator, NA's and in-serviced Burnout to include and symptoms, ways to o do if you observe a mout, was initiated 9/18/14 by o employee will be allowed to go the Burnout in-service. Third employees will review use policy and procedures dation abuse quiz prior to ent during orientation by the II potential employees will be cility for abuse by the Staff employment. This screening is the requesting of information for current employers i.e. checking with the appropriate or registries, and completion of and check. Any employee found on of abuse against them will	F 2	23		

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		COM	(X3) DATE SURVEY COMPLETED C		
		345072	B. WING			/19/2014
	PROVIDER OR SUPPLIER	G AND REHABILITATION CENTE	R	STREET ADDRESS, CITY, STATE, ZIP C 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 223	Facilitator. Staff will answer the questic attempts will be re residents until they knowledge. Staff I knowledge will not facility. The Staff Facilitato in-services for all sand all new orients training before wor Staff to resident in 9/17/14 by Facility to include houseke nursing, interact wand symptom of al interaction will be employees, on all interaction with the will be initiated for inappropriate with limited to, removal resident, suspensi the appropriate Staup to termination. A schedule for depmanger, dietary as director, assistant clerk, medical reconurse, Staff facilitatobserve residents include 3rd shift will per week to include department managobserve all resider fearful (flinching, general states).	age 37 no are unable to correctly ons on the quiz after two moved from working with are able to validate members unable to validate be allowed to work in this or will continue abuse staff monthly for four months ees hired will receive this riking with residents. Iteractions were initiated on Consultant observing how staff eeping, therapy, dietary, ith the residents and for sign ouse. These staff to resident completed with 100% of all shifts, to insure appropriate e resident. The abuse policy any employee found to be a resident to include, but not of the employee from the on, investigation, notification to ate agency, disciplinary action eartment managers, Dietary esistant manager, activity activity director, payroll, supply ords, Administrator, DON, QI tor and MDS nurses (2) to after the hours of 5pm to ll be initiated 9/19/14, 7 days enights and week-ends. The gers will use a checklist and onts for: Does the resident seem uarding, tearful)? Are there any ema, red areas to include the		23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345072	B. WING			C 19/2014	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	<u>, 007</u>	10/2014	
(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 APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 223 F 309 SS=J	for signs and symp any concerns durin manger, dietary as director, assistant a clerk, medical reconurse, Staff facilitat immediately contact Administrator. On 09/19/2014 at 7 was validated and I abated at 7:35 PM staff revealed awar condition and who for training had been record, the physicial resident transferred Interviews revealed had been quarried mistreatment. 483.25 PROVIDE OHIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psychological.	off interactions with residents toms of abuse. If noted to be g the observations, Dietary sistant manager, activity activity director, payroll, supply rds, Administrator, DON, QI for or MDS nurses (2) will set the hall nurse and the contact. Staff verified eness of emergent changes in the contact. Staff verified enesived, that changes in the documented in the medical and should be notified and the differ acute care as indicated. If alert and oriented residents about any concerns of CARE/SERVICES FOR	F 223			10/20/14	
	by: Based on observa	NT is not met as evidenced tion, record review, staff sician interviews, the facility		F309-Asssessment			

PRINTED: 10/14/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 BOILD			(С
		345072	B. WING			09/	19/2014
NAME OF I	PROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CAROLII	NA DIVEDO MUDOINO	S AND DELIABILITATION CENTED	,	18	39 ONSLOW DRIVE EXTENSION		
CAROLII	NA RIVERS NURSING	S AND REHABILITATION CENTER	(JÆ	ACKSONVILLE, NC 28540		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLÉTION DATE
F 309	Continued From pa	age 39	F3	309			
	· ·	e need for medical intervention		,00	" Resident #1 was observed on 9	0/12/14	
		diately initiate emergency			at approximately 6:30am by CNA (I		
		or 1 of 4 residents (Resident			with flushed skin and blood coming		
		acute change of condition.			resident ears. CNA notified nurse of		
		y began on 09/12/2014 when			resident flushed skin and blood cor		
		ound to have a purple face,			from resident #1 ears on 9/12/14. N		
		out of both ears, a bruise on			assessed resident #1 at approxima		
		delayed calling for transport to			6:45 am on 9/12/14 with O2 sats ra		
		proximately five hours after the			92% and skin color slightly purple.	Nurse	
		n was recognized. The			applied O2 and sats went to 97%, t		
		notified of the Immediate			pressure 134/58 and heart rate 98.		
		14 at 7:41 PM. Immediate			Resident #1 was reassessed on 9/		
		oved on 09/19/2014 at 7:35			at approximately 7:00 am by the thi	rd shift	
		mained out of compliance at a			and first shift nurse with no active		
		everity of (D), isolated with			bleeding noted. First shift nurse con		
		than minimal harm that is not			to assess resident #1 on 9/12/14 at		
		y, while the facility completes			am with no active bleeding observe		
		quired. The facility was in the			shift nurse reassessed resident #1		
	corrective action.	ing the implementation of their			9/12/14 around 9:30 am and obser rash on resident face and light	veu a	
	The findings include	lod:			discoloration to resident face. On 9	/12/14	
	The infairigs includ	leu.			9:30am the MD (physician) office r		
	A review of the fac	ility's protocol for			was made aware by first shift nurse		
		OF CHANGES" dated 1/2009,			bleeding from resident #1 ears at 6		
		ility will inform the resident;			rash on face, and light discoloration		
		sident's physician; and if			resident face. Resident #1 was ass		
		esident's legal representative			by first shift nurse again at approximation		
		mily member when there is: *			10:30 am an observed darkening u		
		results in injury and has the			resident □s eyes. On 9/12/14 first s	hift	
		ng physician intervention * A			nurse contacted MD office nurse ag		
	significant change	in the resident's physical,			and notified of darkening under		
		social status" The Notification			resident □s eyes. Order received from		
	· · · · · ·	I had an attached section			office nurse on 9/12/14 approximat		
	1	EPISODE" dated 8/2012. The			11:48am MD order was written to s		
		tocol read as follows: "It is the			resident to ER. Hall nurse assigned		
		to be alert to any change in			resident #1 during the acute chang	e was	
		and to respond in an			drug tested and suspended by the	_	
		er to ensure satisfactory			Administrator on 9/15/14. CNA ass	_	
	intervention treatm	ent for the resident." The			to resident #1 during the acute cha	nge in	

Facility ID: 923029

PRINTED: 10/14/2014 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	·		X3) DATE SURVEY COMPLETED	
		345072	B. WING		09/1	9/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/.	0.2011	
				1839 ONSLOW DRIVE EXTENSION			
CAROLIN	NA RIVERS NURSING	S AND REHABILITATION CENTER	!	JACKSONVILLE, NC 28540			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 309	Continued From pa	age 40	F 309				
1 309	Notification of Charattached section er PHYSICIAN FOR OSCONDITION" dathe policy of the fact when a significant condition occurs within the medical extended the medical occurs and the policy of the fact when a significant condition occurs within the medical extended the medical extended the medical extended the understood, required mobility was severely MDS indicated the understood, required mobility, had contract extremities and contract the staff assessment indicate the predepression, mood of the extended	Inge protocol also had an intitled, "NOTIFICATION OF CHANGE IN RESIDENT ' ted 8/2012 which read, "It is cility to notify the physician change in a resident's ith documentation contained record." Idmitted to the facility on a cute care hospital. Her ses included multiple hagia, muscle weakness, ge, depression, cerebral artery ret, and asthma. inimum Data Set (MDS) dated the resident had long and short tems and decision making of cognitively impaired. The resident was rarely or never ed total assistance for bed actures in both lower all not ambulate. Per the MDS, ant of the resident's mood did esence of any symptoms of disorder or behaviors. In Care, most recently updated atted the resident had feelings ineffective coping arfulness, anxiety and itation. Resident #1's record was rents on 09/12/2014. An entry	F 309	condition was suspended and drug by the Administrator on 9/16/14. At inservice was initiated on 9/12/14 additional inservice was initiated on 9/16/14 with both in-services comp 100% by 9/18/14 with all other licenurses by the Staff Facilitator (Stafeducator) to include LPN #1, LPN LPN #3, and LPN #4 regarding assacute changes in condition, sendin resident out if unable to contact MI examples of acute changes to include abnormal bleeding, notification to physician by telephone when an achange in condition to include cognistatus, behavior, immune system response, normal body system functioning, changes in cognitive schanges in behavior, changes in ointake to include fluids, changes in immune system, changes in normal functioning, Panic laboratory value resident scondition warrants basenurses assessment; If you are used to reach Attending Physician, your On-call for physician; If you are used to reach attending or on-call physician may call the facility Medical Dire Notification of the physician of these of changes in a resident scondition fax is not acceptable. If it warrants the resident to the ER (Emergency Room). Handouts given to staff for reference.	and an an an and an		
	resident was in bed was incontinent and	at 12:15 AM, indicated the d with her eyes closed, that she d required staff turning and entry stated there were no		" Acute Change is defined as ar outside the norm for a resident to i but not limited to abnormal bleedin color changes, changes in behavious	nclude g, skin		

Facility ID: 923029

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG		E SURVEY PLETED
			, J G J		(С
		345072	B. WING _		09/	19/2014
NAME OF F	PROVIDER OR SUPPLIER	!		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
				1839 ONSLOW DRIVE EXTENSION		
CAROLII	NA RIVERS NURSIN	G AND REHABILITATION CENTER		JACKSONVILLE, NC 28540		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	Continued From p acute changes or signed by License The next entry was and read, "CNA (I that resident was I Resident had bloo her face was sligh stated the Resider sat) was 92%. Afte oxygen the O2 sat was 134/58 and he indicated the Directinformed, a voicer the attending physic contact the resp was signed by LPI A physician's telep 11:48 AM stated For the hospital emergence of the physician's telep 11:48 AM stated For the hospital emergence of the physician's telep 11:48 AM stated For the hospital emergence of the physician's telep 11:48 AM stated For the hospital emergence of the physician's telep 11:48 AM stated For the hospital emergence of the physician's telep 11:48 AM stated For the p	age 41 signs of distress. The note was d Practical Nurse (LPN)#1. s dated 09/12/2014 at 6:51 AM Nursing Assistant) informed me bleeding out of her ears. d coming out of her ears and tly purple." The note also nt's oxygen saturation level (O2 er the resident was given awas 97%, the blood pressure eart rate was 98. The note ctor of Nursing (DON) was nail message had been left for dician and the nurse was unable consible party (RP). The note	F 3	DEFICIENCY)	and ness or ne	DATE
	than usual. MD (pl	hysician) made aware. No mber. DON made aware." This		Responsible Party notification change on 9/15/14 by DON, QI nurse, MDS nurses (2) are	on of the acute SDC nurse, and facility	
	read, "Resident be shift. No bleeding to upper face and Upon starting shift around eyes appe	ated 09/12/2014 at 12:15 PM eing assessed throughout the noted thus far, but a rashy area dark circles to Bilat eyes noted. no black circle noted. Area ared to slowly darken ft. Resident continues on 2L O2		consultant. Two concerns we during this audit with reasses resident by the treatment nu 9/16/14, no concerns observ reassessment, and document progress note. " An inservice was initiate	ssment of the rse on red during the ntation in the	

PRINTED: 10/14/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345072	B. WING				0
NAME OF S	200//050 00 01/001/50	34307Z	B. WIIVO		ADDRESS SITV STATE TIP SORE	09/	19/2014
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CAROLI	NA RIVERS NURSING	AND REHABILITATION CENTER			SLOW DRIVE EXTENSION		
G, 11 (G _ 11)				JACKSO	ONVILLE, NC 28540		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	made aware. No ar made aware." The Review of an ambu Care Report" inclu Abdominal Pain. Pr found in bed in nurs observed to be guatwo black eyes, nur how she got the blanot black yesterday on 09/12/2014 at 13 the nursing home at 12:31 PM. The hospital Emerg dated 09/12/2014 in petecchiae to face blood from ears. The patient's throat that prints. I am concern attempted strangular (Department of Sociadmit patient for he be investigated. Pt when I ask her if ar to tear up." The rephysician #1. The Radiology reports and the comp scan was negative mass or hematoma findings. During an interview.	rimacing more than usual. MD newer at RP's number. DON note was signed by LPN#2. Illance transportation "Patient ded, "Chief Complaint: rimary Symptom: Pain. Patient sing home, pt (patient) was urding her abdomen and had rese stated she did not know ack eyes and that they were "The transport note indicated 2:28 PM they departed from and arrived at the hospital at gency Department exam report nocluded, "Patient with and ecchymosis around eyes, here are bruises along the are suspicious for finger ned about elder abuse and ation. Will notify DSS cial Services) and plan to be resafety until this situation can (patient) is nonverbal but hyone hurt her, her eyes began port was signed by Hospital out (dated 09/12/2014) uterized Tomography (CT) for a fracture, there was no a and no other significant on 09/19/2014 at 9:51 AM, #1 discussed her findings	F 3	CNA House any a and o the S and r cond supe an er of TI Wato house any a chan seem comm need in ac usua Dran agita tired, in sk walki usua be al recei C.N./ There agen orien cond 100% nurse LPN comp acute	as to include NA #1 and NA #2, sekeeping, Dietary, therapy state agency/contracted staff on 9/1completed on 9/18/14 on all shaff Facilitator regarding obsereporting changes in resident lition promptly to the staff nurservisor, not leaving the resident mergency situation, and comphe Early Warning Tool Stop and the tool by C.N.A shaft icensed in the seeping, dietary, Therapy state agency/contracted staff on any age in condition noted to including different than usual, talks of municates less than usual, ate less and the confused or nervous more than usual, weight characted or nervous more than usual, weak, confused, or drowsy, or in color or condition, and helping, transferring, toileting more all and given to hall nurse. No sallowed to work until they have inved in-service. All newly hired Aspectation and any newly assignicy staff will be in-serviced in thation regarding acute change lition. An inservice was initiated to follow the service of the servic	aff and 6/14 hifts by rvation is e or during letion durses, aff and acute e erall ipated is than d), age, all, hange with staff will hed with agency #3, and ent of	
		nination of Resident #1 on the			ication to physician by telephor	ne to	

Facility ID: 923029

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345072	B. WING		C 09/19/2014	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 839 ONSLOW DRIVE EXTENSION IACKSONVILLE, NC 28540		
(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 APPROPE DEFICIENCY)	BE COMPLETION	
F 309	said that in addition eyes and on her no bruise on her upper emergency departs #1 said, "We had times to get the list that Resident #1 would have caused Hospital Physician cause that petechia distinctive, pathog characteristic of a sign or symptom made]." The physipetechial rash is in crushing force. I cowould have caused The documentation hospital physician 09/12/2014 include atraumatic except ecchymosis (bruisi eyes). Patient has upper lip up to the indicated there was "on the left side of #2's assessment in case of elderly abuthome staff and the what happened. Patotally bedridden so This has to be invecalled."	age 43 2014. Hospital Physician #1 In to the bruising around her eck, Resident #1 also had a Ir arm when she came into the ment (ED). Hospital Physician to call the nursing home three It of medications" and added asn't on any medications that If the petechiae or bruising. It said, "Very few things will all rash. It is forensically nomonic [specifically disease or condition; denoting on which a diagnosis can be cian further stated, "The dicative of strangulation or a build not find anything else that If it with this patient." In from Resident #1's admitting (Hospital Physician #2) dated and, "Her face appears for large periorbital, infraorbital and under and around the a petechial rash from the forehead." The document also as a little bit of petechial rash the neck." Hospital Physician ancluded, "Petechial rash. Is it a se? We spoke with the nursing y truly do not have any idea of atient is not ambulatory. She is of there was no history of a fall. estigated and DSS will be #2 was interviewed on 4 AM and said, "This patient colained injuries. These were	F 309	include second shift, third shift and weekends; when an acute changes condition occur, including abnorma bleeding, changes in cognitive state behavior, oral changes to include flimmune system response, normal system functioning, Panic laborato values, resident secondition warrar based upon nurse sassessment; are unable to reach Attending Physyou may call On-call for physician; are unable to reach attending or on physician, you may call the facility Medical Director. Notification of the physician of these types of changer resident scondition by fax is not acceptable. In-service was initiated 9/18/14 and completed on 9/21/14 license nurses to include LPN #1, LPN #3, and LPN #4 by Staff Facili on notifying the DON of all acute chin condition. All newly hired license nurses and newly assigned agency will be in-serviced in orientation on notification to the physician of acute changes in resident condition, and notifying DON of all acute changes condition. "The staff nurse will follow up or completed Early Warning Tools by assessing the resident, reporting to Attending Physician and Responsit Party, appropriate interventions init and documentation is in progress in the Early Warning Tool will be place the DON mailbox for review to ensure the resident was assessed, reporting the Poon and Responsition of the physician and Physician and Responsition o	Jus, Juids, Joody ry Just If you Just If y	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(SURVEY PLETED
		345072	B. WING			00/4) 19/2014
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZI	P CODE	09/	13/2014
INAIVIE OF I	-ROVIDER OR SUPPLIER						
CAROLII	NA RIVERS NURSING	S AND REHABILITATION CENTER	1	1839 ONSLOW DRIVE EXTENSION	JN		
				JACKSONVILLE, NC 28540			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD E HE APPROPRI		(X5) COMPLETION DATE
F 309	Continued From pa	age 44 uries." When asked about	F 3	09 Party was completed, app	nronriate		
		or the bleeding from the ears,		interventions initiated and		ation	
		#2 stated that bleeding from		is in progress notes. The			
		lly associated with a skull		responsible to assess, do		ovide	
		ceful coughing. She further		appropriate interventions	•		
		ae is often found with		Attending Physician and			
		rceful vomiting and that the		Party of any acute change noted. The staff nurse w			
		said there was no vomiting. #2 said that tests showed no		appropriate interventions			
		t there was swelling of the soft		needs of the resident and			
		and neck, bruising, and		Physician and Responsib	•	_	
		morrhaging. Hospital Physician		a LPN is on duty and the			
	#2 said, "I don't kn	ow of anything that could		an acute change in condi	tion but the	:	
		her than strangulation when		resident is not sent to the			
		vomiting or forceful cough."		LPN must notify the RN a			
		#2 indicated Resident #1 was		re-assess the resident to			
	still in the hospital.			change in condition does		Ι	
	The facility provide	ed their investigation and written		hospitalization. All staff n		ition	
		ne facility staff taken on		on the 24 hour report/con			
		h 09/17/2014. After review of		board daily. The staff nu			
		nent, the facility staff were		communicate all acute ch		zing	
	interviewed during			the communication board			
				report. Staff will notify the			
		rsing Assistant (NA) #1 wrote,		nurse of any acute chang			
		no falls on 11-7 that I'm aware		nurse, Staff facilitator and			
		(weeks)." An interview was		were in-serviced by the A			
		#1 on 09/18/2014 at 10:42		9/16/14 concerning when			
		ed she was working the 11 PM provided care for Resident #1,		and they receive a call co			
		n who discovered Resident #1,		change in condition of a r			
		. NA#1 stated that the resident		are to ask more question get a clear picture of wha			
		and when agitated, would pull		with the resident. Staff F			
		and incontinent brief. NA #1		include in newly hired Nu			
		night the resident had been		and newly assigned agen			
		g her brief. At approximately		scenarios to include acut			
		oked in to check on the		as: S/SX UTI□s, S/SX	,		
	resident and found	her with the gown pulled up		hyper/hypoglycemia, diffic	culty breath	ing,	
	over her face. NA#	1 said Resident #1 was facing		decreased ability to perfo	rm ADL□s.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDII	···	,	2	
		345072	B. WING _			19/2014	
NAME OF	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COI	•	1012011	
				1839 ONSLOW DRIVE EXTENSION			
CAROLII	NA RIVERS NURSIN	G AND REHABILITATION CENTER		JACKSONVILLE, NC 28540			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	was on the floor. Needs of blood, clofront of her face. It was coming from, turned the resident poured out of her her back and went reported that neith but the NA from the she motioned for her sident #1's room to the room and welf to go get LPN# started to clean Redover blood came of "The nurse sometito get her to calm. all night long, restinot reported the reduction and as I was nurses station I but (Resident #1) was noticed that her face. NA#2 left to get the resident's vinterviewed during 5:20 PM and said, and saw (NA#2) we she said (Resident didn't know why or room and her (Resident Resident Resident).	age 45 I her right side and her sheet IA#1 saw blood on sheet, and se together on the pillow in I'l had no idea where the blood so I went to look." NA #1 It on her back, "and the blood (left) ear" so she turned her on It to look for the nurse. NA#1 I er of the nurses were available the 100 hall was doing care and ther to come with her to IN NA#1 and NA#2 went back then NA#2 saw the resident she the NA#1 stated that when she the sident #1 up and turned her the out of the other ear. NA#1 said, times has to give her medication But not that night, she was up the sident's restlessness to the (NA) #2's undated statement the caring for my residence making my way to the back timped into (NA#1) who said bleeding. As I enter the room I the was blue and that their(sic) the ars." NA#2's statement the sident was scratching her find nurse #1 who told her to the vital signs. NA#2 was the survey, on 9/18/2014 at "I was through with my rounds that you should be and the sident #1's) face was blue and the the sident #1's) face was blue and	F 30	change in bowel/urinary patter bleeding from the ears to insure competent in identifying acuter condition, notifying the MD and the DON. Staff Facilitator will additional training on recognizassessing for acute changes for any nurse that is deemed prior to taking an assignment occur with all new hires, LPNIRNIS. Current residents will be physically observed for acute changes in 24 hour/communication board reviewed, and nurse notes with reviewed weekly XIS 4 week monthly XIS 3 months to insure sident has a change in condition that has a change in condition were initiated timely, and any owere initiated timely utilizing a Change in Condition Monitoria. This will be completed by DO staff facilitator, and/or MDS nuresident medical treatment. In will be provided in the facility in qualified instructor through Early Carolina AHEC on October 15. The Executive QI committee (Administrator, DON, QI, MDS other appropriate persons) with weekly xIS 4 weeks and there	ically icandition, it will be is and then ire that if dition that the MD and RP rders given in Acute ing QI Tool. N, QI nurse, urses. Ivided to all shifts to ind getting is ervicing by a MSN istern is, 2014.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345072	B. WING		09/1	; 9/2014
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540		,	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	On 09/15/2014 LPI of 6:30-6:45ish am (Resident #1) had and was slightly pur room with my vital high and her O2 woxygen put on her re-taken and after limits." LPN#1 was on 09/18/2014 at 1 given the resident (Synthroid and Prilinoticed any agitation ight. LPN#1 state problems during the reported any fall or Resident #1. When of the resident's cosaid, "(NA#2) reported any fall or Resident #1) was she had blood comher left ear. I got viblood coming out of in her face like she oxygen." When as coming from the rewould say it was like gushing but was act that she called LPN#2 went to get the oxygen saturation color started to cor stopped." LPN#1 seridents in the hall she thought had oxidea." LPN#2 said	age 46 N#1 wrote, "Between the times, CNA came and told me that blood coming out of her ear irple in her face. I ran to the sign equipment. Her pulse was as in the low 90s after getting at 2L resident's vitals were were good within normal is interviewed during the survey 1:14 AM, and said she had her scheduled medications osec) around 6AM and had not on at that time or earlier in the did that the resident had not had enight and no one had agitation with regard to a sked how she had learned on the face and hing out of her ear. I think it was tal signs right away. She had of her ear and she was purple wasn't getting enough sked about the amount of blood esident's ears LPN#1 replied, "I see a nose bleed. It wasn't ctively flowing." LPN#1 stated N#2 and #3. She indicated LPN oxygen and the resident's level "started to come up and the back and the bleeding had estated there were no other llways and when asked what occurred she stated, "I have no, "I called the DON and I told was going on the blood.	F 309	review the Acute Change in Cond Monitoring QI Tool to determine to and/or issues that may need furtiinterventions put in place. To dethat need for further and/or frequential monitoring.	trends her termine	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345072	B. WING			C 19/2014
	PROVIDER OR SUPPLIER	S AND REHABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540		
(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 APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 309	I called the doctor nurse came on and asked about what is both ears, LPN#1 s On 09/15/2014 LPI included that LPN# and when she enter NAs were changing saw was approxim (LPN#1 stated that her ears. Resident' told (LPN#1) I wou indicated that LPN# 1's attending physical during the survey chaid "I did see bloograpefruit, maybe 3 pillowcase. The restinged so I went to stated she herself Resident#1 and the and took vital signs might cause bleedi "When (LPN#1) told doctor- that he did DON." When aske hospital to contact hours, LPN#2 indicated the doctor and add her or that I didn't to LPN #3 provided a facility on 09/17/20	that her vital signs were okay, and left a message. The next of I told her everything." When might cause bleeding from said, "I don't know." N#2's written statement of the resident's room the greed the resident's room the greed the resident's room the greed the resident was bleeding from so like the statement of the statement	F 309			
	station, LPN#1 tolo LPN#3 went into R	I her that everything was okay. esident #1's room and saw d on the pillowcase. LPN#3				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION ING	1		E SURVEY PLETED
		345072	B. WING				C 19/2014
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	DE	00/	10/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD I	BE	(X5) COMPLETION DATE
F 309	at 4:15 PM. LPN#3 09/12/2014 she had someone paged for hall. "She (LPN#1) or anything so we ju that when she arriv "(LPN#2) said 'That stated she went to blood in the resider she did not do an a but did ask the NAs "and they all said th she observed fresh donut" on the linen grimacing. She said and added"I would then called the DOI back then I would h On 09/15/2014 the 09/12/2014 at appri received a call from (Resident #1) had se ears and she didn't need to call the doo R.P. (Responsible I okay. I got to the fa 9/12/14 and I had n regarding resident s stated that she had rash on face and da eyes." The DON w survey on 09/18/20 got a phone call fro She said (Resident and she didn't know needed to call the of	ring the survey on 09/19/2014 said that on the morning of d been giving report when all nurses to go to the 200 didn't call any kind of a code ust walked there." LPN#3 said ed at the nursing station, it's okay, we got it." LPN#3 Resident #1's room and saw at's right ear. LPN## stated assessment of the resident in the room what happened, and the resident was and the resident was and the resident was and the doctor and have called the doctor didn't call ave called the DON again."	F3	09			

AND BLAN OF CORRECTION TO IDENTIFICATION NUMBERS		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345072	B. WING		09/1	; 9/2014
	PROVIDER OR SUPPLIER	S AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	1 03/1	3/2014
(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 APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	thought it was a sk something. I didn't but I did tell her to added, "I should h The DON said she (LPN#4) and learnears had stopped to room to assess the stated that a lot of could be a sign of a have expected her hospital when they have since learned nurse did not hear the resident should for evaluation. The LPN#1 had called message on the arrequest the DON roposted at the nursi off-hours paging not posted at the desk none of the Registe that Friday morning Resident #1. LPN#4's undated stold by the off-going had been bleeding mentioned to anoth attempted to get in doctor but never ta statement also included back of my mind I'mpaged at some poisoon." The statement checked the reside	resident's ears and said, "I in tear or scratch or think it was anything emergent call the doctor." The DON ave been more inquisitive." spoke to the day shift nurse ed that the bleeding from the out the DON did not go to the eresident herself. The DON blood from a resident's ears a head injury and said, "I would (LPN#1) to send her to the saw the amount of blood I of." The DON said if the back from the physician that I have been sent to the hospital DON said she learned that the physician's office and left a newering machine. Upon eviewed the physician numbers and station and said the umber for that doctor was not and the DON also indicated that ered Nurses in the building on gof 09/12/2014, had assessed estatement indicated she was go 11-7 nurse that Resident #1 from her ears. "The nurse her that it was a lot. She touch with the resident's liked to him." LPN#4's uded, "All the while in the mothinking her doctor was not and he should be calling tent indicated LPN#4 had that a approximately 8:30 AM are tive bleeding from the ears.	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345072	B. WING _				C 19/2014	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE	
F 309	the resident had de eyes and there was face. "I then called to see why they had about the rash. I sp told her about the bas well. She stated call back. Not even to have dark circles pooled there. I called them know and four MD said that he ne calls from anyone a instructed to send the for evaluation. Resident has sustain unaware of any recinterviewed during 10:08 AM. She stated was a light purple of her face and the forehead too. "I was back and I continue stated that about on checked the resident 2L per minute. Swent in to change a rash on the resident said she called the and then about an the dark circles for called the physiciar went out to the hos LPN#4 said, "I thouges started to turn eyes started to turn the control of the control of the control of the physiciar went out to the hos LPN#4 said, "I thouges started to turn the control of the cont	incomes but about an hour later eveloped a rash around her is some discoloration on her id the MD's (physician's) office dri't called and to tell them toke with the MD's nurse and eleeding from the previous shift she would let him know and an hour later resident began and under her eyes like blood had an hour later resident began and under her eyes like blood had an hour from the nurse that the over received any pages or about the matter. I was he resident out to the hospital ident was alert with eyes open as asked by MD's office if and any falls but I was ent falls." LPN#4 was the survey on 09/18/2014 at ed when she examined dri't see any blood but there discoloration on the right side discoloration was on her as waiting for the doctor to call and with my med-pass." LPN#4 he and a half hours later she int and the oxygen was still on he said the treatment nurse and dressing and identified the treatment nurse hour and a half later she noted ming under her eyes and it's face as petechiae. LPN#4 attending physician's nurse hour and a half later she noted ming under her eyes and it's office again. The resident pital at approximately noon. Light she had fallen when her black but night shift said she she was in bed all day for us	F 30	09				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345072	B. WING _			19/2014	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 309	closed head injury added, "I called th (Resident #1) out." During an interview the Administrator s (LPN#1) to do a fu expected her to ca (the DON) to have that assessment." During an interview Resident #1's atters stated, "I was infoleen waiting for a know anything about bleeding from both stated the resident that would cause be petechiae. The phythen urse to send if the was bleeding from emergency. They have with experience is The Administrator Jeopardy for F309 The facility provide allegation of completion of completion of completions and blood considerable skin and blood consi	In't have a fall. I was thinking or that she had fallen." She e DON to tell her I was sending or on 09/19/2014 at 5:15 PM, aid, "I would have expected assessment. I would have all 911. I would have expected more discussion regarding of on 09/25/2014 at 9:11 AM, ading physician in the facility and that the day nurse had call back from me but I didn't aut an earlier call about the ears earlier." The physician was not on any medications aleeding from the ears or ysician said, "I would expect the to the hospital to see why from the ears." He added, and the ears) was definitely and have to make sure someone there to take charge." Was notified of the Immediate on 9/18/14 at 7:41 PM. If the following credible beginned on 9/19/14 at 5:00 PM.	F 30				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X	(3) DATE SURVEY COMPLETED	
		7. BOILB			С	
	345072	B. WING			09/19/2014	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD)E		
CAROLINA BIVERS NURSING	AND DEHABILITATION CENTER	,	1839 ONSLOW DRIVE EXTENSION			
CAROLINA RIVERS NURSING	AND REHABILITATION CENTER	Ĺ	JACKSONVILLE, NC 28540			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BI		
assessed resident # on 9/12/14 with O2 scolor slightly purple. went to 97%, blood rate 98. Resident # at approximately 7:0 first shift nurse with First shift nurse conton 9/12/14 at 8:30 at observed. First shift #1 on 9/12/14 around rash on resident face. On 9/ (physician) office nutshift nurse of bleeding 6:30am, rash on face resident face. Resid shift nurse again at observed darkening 9/12/14 first shift nurse again at observed darkening 9/12/14 first shift nurse again and notified of eyes. Order receives 9/12/14 approximate written to send resident was drug tested and Administrator on 9/1 #1 during the acute suspended and drug on 9/16/14. An insert and an additional ins 9/16/14 with both inby 9/18/14 with all of Staff Facilitator (Statassessing acute charesident out if unable acute changes to income.	nt #1 ears on 9/12/14. Nurse #1 at approximately 6:45 am sats range at 92% and skin. Nurse applied O2 and sats pressure 134/58 and heart #1 was reassessed on 9/12/14 00 am by the third shift and no active bleeding noted. Intinued to assess resident #1 am with no active bleeding to nurse reassessed resident and 9:30 am and observed a see and light discoloration to 1/12/14 9:30 am the MD urse was made aware by first and from resident #1 ears at see, and light discoloration to 1/12/14 9:30 am the MD urse was made aware by first approximately 10:30 am and gunder resident's eyes. On a under resident's eyes. On a under resident's eyes on ely at 11:48 am MD order was dent to ER. Hall nurse to the the same was dent to the extended the exte	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	345072	B. WING		09	/19/2014
NAME OF PROVIDER OR SUPPLIER	1	•	STREET ADDRESS, CITY, STATE, ZIP COD	•	
CAROLINA RIVERS NURSING	AND REHABILITATION CENTER	1	1839 ONSLOW DRIVE EXTENSION		
			JACKSONVILLE, NC 28540		
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status, behavior, im normal body system cognitive status, cha oral intake to includ system, changes in Panic laboratory val warrants based upour are unable to reach call On-call for physican of these the facility's Medical physician of these the resident's condition warrants send the resident's condition warrants send the receiving the in-service will be allowed receiving the in-service in abilities to change in abilities to change in abilities to change in appetite, chew/swallow food, complaints of dizzing elimination habits, of the condition to include bleeding on 9/15/14 Development Coord Improvement) nurse consultant. Four consultant.	Indition to include cognitive amune system response, in functioning, changes in anges in behavior, changes in ale fluids, changes in immune a normal body functioning, lues, resident's condition on nurse's assessment; If you attending Physician, you may sician; If you are unable to con-call physician, you may call all Director. Notification of the types of changes in a by fax is not acceptable. If it resident to the ER (Emergency given to staff for reference. No ed to work without first vices. Inge is defined as anything or a resident to include but not bleeding, skin color changes, ors, change in mental alertness reased weakness or fatigue, o feed, bathe, or groom self, llance, transfer, or walk,	F 3	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345072	B. WING		09	C / 19/2014
	PROVIDER OR SUPPLIER	S AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	•	710/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 309	MD and RP notification progress notes. The were reviewed to exchanges in condition color and bleeding appropriate interver Physician notification of the arm DON, SDC nurse, facility consultant, during this audit wiresident by the treat concerns observed documentation in the An inservice Housekeeping, Disagency/contracted the Staff Facilitator reporting changes to the staff nurse or resident during an completion of The Watch" tool by N./. housekeeping, die agency/contracted condition noted to usual, talks or compoverall needs more in activities less that (not because of disusual, weight chanthan usual, tired, we change in skin colowalking, transferring and given to hall not to work until they have a supplementation.	4 with interventions placed, ation, and documentation in the aree months of nurse's notes ansure all documented acute on to include changes in skin have been addressed with antions placed, Attending on and Responsible Party acute change on 9/15/14 by QI nurse, MDS nurses (2) and Two concerns were noted the reassessment of the atment nurse on 9/16/14, no I during the reassessment, and	F3	09		

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		345072	B. WING _			C 19/2014	
	PROVIDER OR SUPPLIER	S AND REHABILITATION CENTER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	1 03/	13/2014	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 309	staff will be in-serv acute changes in a initiated with 100% agency nurses initiassessment of acute sending resident or notification to phys second shift, third acute changes in abnormal bleeding behavior, oral charsystem response, functioning, Panic condition warrants assessment; If you Physician, you may you are unable to rephysician, you may Director. Notificat types of changes in is not acceptable. by Staff Facilitator acute changes in acut	age 55 any newly assigned agency iced in orientation regarding ondition. An inservice was of license nurses to include ated on 9/12/14, on te changes in condition, at if unable to notify MD, ician by telephone to include shift and weekends; when an ondition occur, including changes in cognitive status, ages to include fluids, immune normal body system laboratory values, resident's based upon nurse's are unable to reach Attending call On-call for physician; If each attending or on-call or call the facility's Medical ion of the physician of these in a resident's condition by fax In-service was initiated 9/18/14 on notifying the DON of all ondition. All newly hired din normal to a language of the changes in resident to ute changes in resident to ute changes in resident and appropriate interventions in a progress notes.	F 30	,			
	mailbox for review assessed, reporting Responsible Party	Tool will be placed in the DON to ensure that the resident was g to Attending Physician and was completed, appropriate ed and documentation is in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` ,	(X3) DATE SURVEY COMPLETED	
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		345072	B. WING		09	/19/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	•		
CAROLII	LA DIVEDO MUDOINA	C AND DELIABILITATION CENTED		1839 ONSLOW DRIVE EXTENSION			
CARULII	NA RIVERS NURSING	G AND REHABILITATION CENTER		JACKSONVILLE, NC 28540			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 309	assess, document interventions and responsible Party condition noted. Tappropriate interventies the resident and notes as a staff nurses will do condition on the 24 board daily. The sacute changes util during shift report. on-call nurse of an nurse, Staff facilitatin-serviced by the concerning when the receive a call concarresident that the needed, to get a cliwith the resident Snewly hired Nurses assigned agency sinclude acute charges in contacting the DOI additional training for acute changes	he staff nurse is responsible to provide appropriate notify Attending Physician and of any acute changes in the staff nurse will implement entions based on the needs of otify Attending Physician and when a LPN is on duty and ad an acute change in condition not sent to the hospital, the e RN and the RN must dent to insure the acute change in the total more than acute changes in the total more than acute changes. DON, QI was total more than acute change in condition of the total more than acute than acu	F3	309			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345072	B. WING		09/1	C 19/2014
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	1 03/1	13/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	LPN's and RN's. On 09/19/2014 at 7 was validated and I abated at 7:35 PM staff revealed awar condition. Staff veri received, that chan documented in the be involved in the a should be notified a acute care as indicatif the attending or o reached, the facility called. The number	ge 57 vill occur with all new hires, :10 PM the credible allegation mmediate Jeopardy was when interviews with nursing eness of emergent changes in fied training had been ges in condition were to be medical record, an RN was to ssessment, the physician and the resident transferred for ated. Interviews revealed that n-call physician could not be it's Medical Director should be r for paging the physicians as hours was posted at the	F 309			