PRINTED: 12/08/2014 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	
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		345314	B. WING			11/	20/2014
	ROVIDER OR SUPPLIER CITY HEALTH AND REHA	BILITATION CENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 30 BETHANY CHURCH ROAD FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD E			(X5) COMPLETION DATE
F 241 SS=D	manner and in an envenhances each reside full recognition of his of the second full recognition and staff interviews the resident to the bathrous episodes for 1 of 3 reserviewed for dignity at the findings included:  Resident #45 was addrou/30/10 with diagnost anxiety and chronic of disease. The quarterly dated 08/18/14 reveal cognitively intact and sunderstood. The MDS #45 required extension and was occasionally  Review of Resident #405/14/14 revealed she incontinence with a gowaking hours. The interesident had an unobstrestroom, have call light change clothing as ne episodes.  An interview was conducted.	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.  It is not met as evidenced ones, record review, resident he facility failed to assist a for resulting in incontinence sidents (Resident #45) and respect.  Individuality.  Indivi	F	241	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and states law.  F241  1. Corrective action has been accomplished for the alleged deficient practice for Resident # 45 by providing timely toileting assistance of care rounds and as needed maintain their dignity.  Black trouble by:  OEC 1 7 2016  Black trouble by:  OEC 1 7 2016  DEC 1 7 2016	f or e d te	(X6) DATE

Administrator

12-17-2014

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345314	B. WNG _		C 11/20/2014	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 830 BETHANY CHURCH ROAD FOREST CITY, NC 28043	1 1112/12/14	
(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 APPROPRI DEFICIENCY)	BE COMPLETION	
F 241	light in time for her to stated she had been a accidents a week that and gown to be chang waits during the night very embarrassed who bed.  An interview was come AM with NA #4. She is PM to 7:00 AM shift on Rehabilitation hall. She residents per shift and received the care they staffing. She reported Rehabilitation hall she on B hall and resident call lights to be answered. An interview was come AM with NA #1. She is PM to 7:00 AM shift of was very difficult to ke clean, dry, turned and she answered call light but some residents who by the time she was a #1 stated Resident #4 incontinence because her call light soon end. An interview was come AM with NA #2. She is PM to 7:00 AM shift. Since the call light soon end. An interview was come AM with NA #2. She is PM to 7:00 AM shift. Since the call to keep the them to the bathroom.	if staff answered her call get to the bathroom. She having 1 to 2 incontinence required her bed sheets ged due to long call light. She further stated she felt en she had accidents in the ducted on 11/20/14 at 6:40 stated she worked the 11:00 in B hall and the se stated she had up to 32 didn't feel like they in needed because of if she was on the e could not see the call lights is had long wait times for ered.  Inducted on 11/20/14 at 6:45 stated she worked the 11:00 in Resident #45's hall and it is as quickly as she could ere soaked to the mattress ble to get to their room. NA 5 had several incidents of she wasn't able to answer	F 2	2. Residents who require assistance with toileting the potential to be affect by the same alleged deficient practice; therefore, the Resident Care Managem Director has conducted a audit of current resident toileting needs. C.N.A. Care Grids have been reviewe and updated, as needed, reflect the residents' cur toileting needs. The Social Services Director has identified Residents who capable of participating interviews regarding timeliness of toileting assistance.  3. Measures put into place ensure that the alleged deficient practice does not recur include: in-service nursing staff related to the same alleged to the same	ted cient ent ent ent an s' are d to rent al are n	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE COMP	SURVEY
		345314	B. WNG			C 20/2014
NAME OF P	ROVIDER OR SUPPLIER		- <del></del>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 17	20/2014
				830 BETHANY CHURCH ROAD		
FOREST	CITY HEALTH AND REHA	BILITATION CENTER		FOREST CITY, NC 28043		
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F 241	Continued From page	2	F 24	11		
	through to the mattres	ss due to having to wait so				
	long to be changed.	For subsected or his departments of a subsective of subsective of the subsective of		promotion of care for		
				residents in a manner and in		
		ducted with the Director of		an environment that		
		20/14 at 2:30 PM. He stated that resident call lights be		maintains or enhances		
	Total Control of the	manner so incontinence				
	episodes could be ave			residents' dignity and respect		
F 309	State Control of the		F 30	in full recognition of his or		12-18-14
SS=D	HIGHEST WELL BEIN			her individuality; specifically,		12/9/1
				offering timely toileting		
		ceive and the facility must care and services to attain		assistance as needed to aid in		
		st practicable physical,		the prevention of		
	mental, and psychoso			incontinence. Residents will		
		omprehensive assessment		be assessed upon admission,		
	and plan of care.			quarterly, annually and with		
				significant change via the		
				MDS process with care plan		
	This REQUIREMENT	is not met as evidenced		interventions identified per		
	by:			individual. C.N.A. Care Grids		
		ns, record review, and staff failed to provide positioning		will be updated by Nursing		
		lowed a resident's feet to		Administration as changes in		
		degree angle for 1 of 2		toileting assistance are		
	residents reviewed for	well being (Resident		identified. At least 25% of		
	#101).			interviewable residents who		
	The findings included:			require toileting assistance		
	me imangs madded.			will be interviewed by the		
	Resident #101 was re	admitted to the facility		Social Services Director to		
	04/29/14 with diagnos			identify concerns related to		
	[ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [	nistory of falls, and muscle		timely toileting assistance on		
		Minimum Data Set (MDS) ted the resident's cognition		a monthly basis for three		
		I, could be understood, and		months. Resident Council		
	understands others.			meetings will include		

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		345314	B. WING			111	20/2014
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	11/2	20/2014
FOREST	CITY HEALTH AND REHA	BILITATION CENTER		24-22	0 BETHANY CHURCH ROAD DREST CITY, NC 28043		
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F 309	assistance of 2 people to surface.  An observation on 11/Resident #101 was si propelling down the hypropelling by slowly to with his hands and pullocated on the side of observed pointed down floor. His heels were his toes and not touch were observed on the  An observation on 11/Resident #101 was sit propelling out of his repropelled by slowly rowith his hands. His to downward and touchir observed suspended were observed on the  An observation on 11/Resident #101 was set the breakfast table in the floor. His heels we floor. No footrests we wheelchair.  Continued observation and 1:25 PM revealed hallway sitting in his we pointed downward and content of the floor.	t ambulate during the and required limited staff are for transfers from surface.  Italian at 4:11 PM revealed atting in his wheelchair self all. He was observed self urning the wheelchair wheels alling on the hand rails the hallway. His toes were arrowed and touching the observed suspended above using the floor. No footrests wheel chair.  Italian at 7:26 AM revealed atting in his wheelchair self and the wheelchair wheels are were observed pointed and the floor. His heels were off the floor. No footrests wheelchair.  Italian at 8:31 AM revealed atted in his wheelchair at the dining room. His toes and downward and touching are suspended above the	F	309	questions regarding timely toileting assistance bi-weekly for 1 month, then monthly for the next 3 months. The Administrator will review the minutes for concerns and timely response to noted concerns. Care Rounds will be completed by Nursing Administration daily for one week then at least weekly for 3 months to identify concerns with timely toileting assistance to ensure continued compliance.  4. The Director of Nursing and Administrator will review data obtained during rounds, Resident Council minutes and Resident interviews, analyze the data and report	r g	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TON NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	040014	I		TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	/20/2014
	CITY HEALTH AND REHA	BILITATION CENTER		8	30 BETHANY CHURCH ROAD FOREST CITY, NC 28043		
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	on 11/19/14 at 1:28 Proportion of the property in a wheelchar knees, and ankles shouring the interview, the street of the property in a wheelchar knees, and ankles shouring the interview, the street of the street of the property of the street of the property of the street of the property of the street of the	Occupational Therapist (OT) M revealed when positioned air, the resident's back, hips, buld be at 90 degree angles. The OT observed Resident belchair with his heels not be OT confirmed Resident with his ankles at 90 degree bident was asked if he could hair with his feet, he was bels on the floor. The did moving his wheelchair by bels with his hands while his befloor.  Soluted with Nursing 11/19/14 at 3:01 PM. NA #4 did in the facility since the 2014. She added she had \$\frac{1}{2}\$101's feet fully touch the stoes touched the floor but serve residents for ing.  Manager on 11/20/14 at was unaware Resident ch the floor at a 90 degree	F3		patterns/trends to the QAPI committee every other month for 6 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions, based on identified outcomes, to ensure continued compliance.		10.19.14
	483.25(k) TREATMEN NEEDS	T/CARE FOR SPECIAL	F3	28			12-18-14

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Movember and the second	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 830 BETHANY CHURCH ROAD FOREST CITY, NC 28043			
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F 328	proper treatment and special services: Injections; Parenteral and entera Colostomy, ureterost: Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT by: Based on observation interviews, the facility tubing utilized for interaction of the special succession of the service	ure that residents receive care for the following	F3	F309  1. Corrective action was accomplished on 11 for the alleged deficing practice in regards to Resident # 101 by completing a Physic Therapy evaluation determine positionine needs while in the wheelchair. Resider 101 is able to prope wheelchair with his fully touching the fla 90 degree angle.	/20/14 cient co ral to ng nt #		
	revised June 2012 an administration of med infusion revealed in p administration sets withours. The policy als will be knowledgeable aseptic intermittent at medications and fluid Resident #58 was adwith diagnoses which	ion Administration Policy of related to intravenous lications via intermittent art intermittent ill be changed every 24 or contained licensed nurse e regarding the safe and dministration of intravenous s.		2. Residents who utilize wheelchair for mobe have the potential to affected by the same alleged deficient protection of their same alleged deficient protection of their same of the same of the same of the same of the same of their same of t	ility o be e actice; b and/or pist dents		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
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NAME OF D	ROVIDER OR SUPPLIER	345514		STREET ADDRESS, CITY, STATE, ZIP CODE	11/20/2014
	CITY HEALTH AND REH	ABILITATION CENTER		830 BETHANY CHURCH ROAD FOREST CITY, NC 28043	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 328	A review of Resident revealed a physician order specified to adr 2 grams intravenousl days for a urinary tra  On 11/19/14 at 9:20 administering Fortaz bag labeled as Fortat from an IV holder wit threaded through an was observed removinserting the existing with Fortaz and dated proper procedure of with the new Fortaz rneedle already insert starting the current at When asked, Nurse schanged every 72 hofind any indication/datubing was last changed.  A review of Resident Administration Record, and nurses rdocumentation of whe last changed.  An interview with the Corporate Nurse Cord AM revealed the facility folloglicy the facility folloglicy the facility folloglicy medication administration	#58's medical record s order dated 11/15/14. The minister Fortaz (an antibiotic) y (IV) every 12 hours for 7 ct infection.  AM Nurse #1 was observed to Resident #58. An empty z was observed hanging in the tubing from the bag infusion pump. Nurse #1 ing the empty bag and tubing into a full bag labeled to 11/19/14. She followed the priming the existing IV tubing mixture, flushing the reusable ed in the resident's arm, and diministration of Fortaz. #1 stated IV tubing should be urs. Nurse #1 was unable to the of when the existing IV ged.  #58's Medication d, Treatment Administration notes revealed no en intermittent IV tubing was  Unit Coordinator and the isultant on 11/19/14 at 10:48 ity pharmacy provided the wed for intravenous inistration. She stated the	F 328	to ensure they can propal	
	policy included time f	rames regarding changing Coordinator stated ation administration required			

NAME OF PROVIDER OR SUPPLIER  POREST CITY HEALTH AND REHABILITATION CENTER  POREST CITY (ACATION STANDARD OF DEPOCIENCES TO THE APPROPRIATE DEPOCIENCES TO	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTIO A. BUILDING			(X3) DATE SURVEY COMPLETED					
STREET ADDRESS, CITY, STATE_ZIP CODE 330 BETHANY CHURCH ROAD POREST CITY HEALTH AND REHABILITATION CENTER   330 BETHANY CHURCH ROAD POREST CITY, NC 28043   200 BETHANY CHUR			345314	B. WNG_				-	
F 328 Continued From page 7 continuous IV fluid administration required changing IV tubing every 72 hours. The Corporate Nurse With Nurse #2 on 11/19/14 at 12:09 PM revealed IV tubing should be changed every 72 hours for intermittent IV medication administration.  An interview with Nurse #3 on 11/19/14 at 12:10 PM revealed IV tubing should be changed every 72 hours for intermittent IV medication administration.  An interview with Nurse #3 on 11/19/14 at 12:10 PM revealed IV tubing should be changed every 72 hours for intermittent IV medication administration.  An interview was conducted with the Director of Nursing (DON) on 11/20/14 at 9:45 AM. The DON stated his expectation was for all nurses to know when IV tubing should be changed during intermittent and continuous IV medication/fluid administration.  F 353 483.30(a) SUFFICIENT 24-HR NURSING STAFF PSS=D  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident			BILITATION CENTER		8	30 BETHANY CHURCH ROAD			
continuous IV fluid administration required changing IV tubing every 72 hours. The Corporate Nurse Consultant added the tubing should be labeled with the date it was changed.  An interview with Nurse #2 on 11/19/14 at 12:09 PM revealed IV tubing should be changed every 72 hours for intermittent IV medication administration.  An interview with Nurse #3 on 11/19/14 at 12:10 PM revealed IV tubing should be changed every 24 hours for intermittent IV medication administration.  An interview was conducted with the Director of Nursing (DON) on 11/20/14 at 9:45 AM. The DON stated his expectation was for all nurses to know when IV tubing should be changed during intermittent and continuous IV medication/fluid administration.  F 353 SS=D  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI			COMPLETION	
care plans:  Except when waived under paragraph (c) of this  locomotion/mobility  status. Care Rounds will  be conducted daily for one	F 353	continuous IV fluid add changing IV tubing ever Corporate Nurse Conshould be labeled with An interview with Nurse PM revealed IV tubing 72 hours for intermitter administration.  An interview with Nurse PM revealed IV tubing 24 hours for intermitter administration.  An interview was considered in the construction of the const	ministration required rery 72 hours. The sultant added the tubing in the date it was changed.  se #2 on 11/19/14 at 12:09 g should be changed every ent IV medication  se #3 on 11/19/14 at 12:10 g should be changed every ent IV medication  ducted with the Director of (20/14 at 9:45 AM. The station was for all nurses to should be changed during nuous IV medication/fluid  AT 24-HR NURSING STAFF  e sufficient nursing staff to selated services to attain or oracticable physical, mental, being of each resident, as in assessments and e.  de services by sufficient e following types of ur basis to provide nursing accordance with resident			psychosocial well-being, specifically, that residents who self-propel in a wheelchair are capable of doing so with their feet fully on the floor and that if/when a resident exhibits a change in this ability then communication will be provided to the therapy department for screening or evaluation to address the need. The Occupational Therapist or other appropriate therapy discipline will continue to review the identified residents noted above until all have been screened and/or evaluated. Residents will be reviewed at least quarterly via the MDS process to assess locomotion/mobility status. Care Rounds will		12-18-14	

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	345314	B. WNG				C 20/2014	
	BILITATION CENTER		830	BETHANY CHURCH ROAD		8	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
section, licensed nursipersonnel.  Except when waived section, the facility minurse to serve as a cluty.  This REQUIREMENT by: Based on observation and staff interviews the assistance with toileting due to insufficient nur residents (Resident #4 The findings included 1. Resident #45 was 04/30/10 with diagnost obstructive pulmonary Minimum Data Set (Norevealed Resident #4 MDS further revealed extensive assistance Review of Resident #4 MDS further revealed extensive assistance with a gwaking hours. The interesident had an unobrestroom, have call light change clothing as neepisodes.  A review of staffing as respisodes.	under paragraph (c) of this ust designate a licensed harge nurse on each tour of is not met as evidenced has, record review, resident he facility failed to provide high and incontinence care sing staff for 3 of 3 45, #73, #47).  Standmitted to the facility on see of anxiety and chronic of disease. The quarterly IDS) dated 08/18/14 to was cognitively intact. The Resident #45 required with toileting.  45's care plan dated he was care planned for coal to be continent during erventions included ensure structed path to the ght within easy reach and deded after incontinence resignments from May 2014	F	353	week then at least weekly for three months to monitor for concerns related to wheelchair positioning. If changes in locomotion using a wheelchair are identified as part of the MDS process or during care rounds, the Interdisciplinary Team will complete a referral to Therapy Service via In-House Communication Form.  4. The Director of Nursing and Administrator will review the results of care rounds and referrals, analyze the data and report patterns/trends to the QAPI committee every other month for 6 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional			
through November 20	, 2014 revealed 3 nurse			add additional			
	CONTINUED OR SUPPLIER  SUMMARY STI  (EACH DEFICIENCY REGULATORY OR LE  Continued From page section, licensed nurs personnel.  Except when waived section, the facility munurse to serve as a characteristic of the continued section of the facility munurse to serve as a characteristic of the continued section of the facility munurse to serve as a characteristic of the continued staff interviews the assistance with toileting due to insufficient nur residents (Resident #4 The findings included 1. Resident #45 was a 04/30/10 with diagnos obstructive pulmonary Minimum Data Set (Morevealed Resident #4 MDS further revealed extensive assistance Review of Resident #4 MDS further revealed extensive assistance Review of Resident #4 most further second of the continuence with a gray waking hours. The interest of the continuence with a gray waking hours. The interest of the continuence with a gray waking hours. The interest of the continuence with a gray waking hours. 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This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide assistance with toileting and incontinence care due to insufficient nursing staff for 3 of 3 residents (Resident #45, #73, #47).  The findings included:  1. Resident #45 was admitted to the facility on 04/30/10 with diagnoses of anxiety and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) dated 08/18/14 revealed Resident #45 was cognitively intact. The MDS further revealed Resident #45 required extensive assistance with toileting.  Review of Resident #45's care plan dated 05/14/14 revealed she was care planned for incontinence with a goal to be continent during waking hours. The interventions included ensure resident had an unobstructed path to the restroom, have call light within easy reach and change clothing as needed after incontinence	This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide assistance with toileting and incontinence care due to insufficient nursing staff for 3 or sresidents (Resident #45, #73, #47).  The findings included:  1. Resident #45 was admitted to the facility on 04/30/10 with diagnoses of anxiety and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) dated 08/18/14 revealed she was care planned for incontinence with a goal to be continent during waking hours. The interventions included ensure resident had an unobstructed path to the restroom, have call light within easy reach and change clothing as needed after incontinence episodes.  A review of staffing assignments from May 2014 through November 20, 2014 revealed 3 nurse	A BUILDING  345314  B. WING  STR  STR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8 section, licensed nurses and other nursing personnel.  Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.  This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide assistance with toileting and incontinence care due to insufficient nursing staff for 3 of 3 residents (Resident #45, #73, #47).  The findings included:  1. Resident #45 was admitted to the facility on 04/30/10 with diagnoses of anxiety and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) dated 08/18/14 revealed Resident #45 was cognitively intact. The MDS further revealed Resident #45 required extensive assistance with toileting.  Review of Resident #45's care plan dated 05/14/14 revealed she was care planned for incontinence with a goal to be continent during waking hours. The interventions included ensure resident had an unobstructed path to the restroom, have call light within easy reach and change clothing as needed after incontinence episodes.  A review of staffing assignments from May 2014 through November 20, 2014 revealed 3 nurse	A BUILDING  345314  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 830 BETHANY CHURCH ROAD FOREST CITY, NC 28043  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPOCENCY MUST BE PRECEDED BY FULL (EEGCH DEPOCENCY MUST BE PRECEDED BY FULL (EEGCH DEPOCENCY MUST BE PRECEDED BY FULL (EEGCH ADDRESS, CITY, STATE, ZIP CODE 830 BETHANY CHURCH ROAD FOREST CITY, NC 28043  PROVIDER'S CITY, NC 28043  FOREST CITY, NC 28043  FROUDER'S CITY, NC 28043  FROUDER'S CITY, NC 28043  FOREST CITY, NC 28044  FOREST CITY ACH CACH CORECT CITY AND CORSTANT CITY AND CORSTANT CITY AND CORSTANT CITY AND	A BUILDING  345314  B. WANG  STREET ADDRESS, CITY, STATE, 2IP CODE  30 BETHANY CHURCH ROAD FOREST CITY, NC 28043  SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST EPRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  section, licensed nurses and other nursing personnel.  Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.  This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide assistance with tolleting and incontinence care due to insufficient nursing staff for 3 of 3 residents (Resident #45, #73, #47).  The findings included:  1. Resident #45 was admitted to the facility on O4/30/10 with diagnoses of anxiety and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) dated 08/18/14 revealed Resident #45 scare plan dated 05/14/14 revealed she was care planned for incontinence with a goal to be continent during waiking hours. The interventions included ensure resident had an unobstructed path to the restroom, have call light within easy reach and change clothing as signments from May 2014 through November 20, 2014 revealed 8 nurse  Towns and referrals, analyze the data and report patterns/trends to the QAPI committee every other month for 6 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245244	B. WNG	_			C
Mark 1992 1997 1997 1997		345314	B. WING			11/	20/2014
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST (	CITY HEALTH AND REHA	BILITATION CENTER			30 BETHANY CHURCH ROAD		
				F	OREST CITY, NC 28043		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	Of Carrier	(X5) COMPLETION DATE
F 353	Continued From page	9	F:	353	interventions, based on		
		shift and 12 days out of that	0.516 23		identified outcomes, to		
	time period there were 2 NAs scheduled to work				ensure continued		
	the 11:00 PM to 7:00						
			1		F328 compliance.		
		ent Council Meeting minutes			1. Corrective action has		
	dated 05/2014 throug	ints about long call bell wait			been accomplished for the	3	
3	[[[[[[[[] [[] [[] [[] [[] [[] [] [] [] [	J. The August 19, 2014			alleged deficient practice		
		omplaint that there was not			in regards to Resident #58		
		1:00 PM to 7:00 AM shift			by discarding the		
		oo long to be changed. entation in the minutes of			unlabeled infusion tubing		
		ong call light wait times or					
	insufficient staffing on				set on 11/19/14. The		
					resident no longer		
		ducted on 11/20/14 at 6:40 stated she worked the 11:00			receives intravenous		
	PM to 7:00 AM shift o				therapy. One to one		
		e stated she had up to 32			education with Nurse #1		
	residents per shift and				and Nurse #2 was		
	received the care they staffing. She reported				completed by the Director	r =	
		could not see the call lights			of Nursing on 11/19/14.		
	on B hall and resident call lights to be answer	s had long wait times for ered.			Of Nursing Off 11/13/14.		
		ducted on 11/20/14 at 6:45			2. Residents who require		
	and a state of the following of the state of	tated she worked the 11:00			intravenous medication		
		n Resident #45's hall and it			have the potential to be		
		ep all the residents toileted,			affected by the same		
		repositioned. She stated ats as quickly as she could			alleged deficient practice;		
		ere soaked to the mattress			therefore, the Director of		
		ble to get to their room. NA			12.		
		5 had several incidents of			Nursing has completed an		
		she wasn't able to answer	K.		audit of residents		
	her call light soon eno	ugn.			currently receiving IV		
	An interview was cond	ducted on 11/20/14 at 6:50			medications.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000 1000	(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED		LETED	
		345314	B. WING_			11/2	20/2014
	ROVIDER OR SUPPLIER	BILITATION CENTER		830	REET ADDRESS, CITY, STATE, ZIP CODE BETHANY CHURCH ROAD REST CITY, NC 28043	, , , , , ,	20/2014
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	AM with NA #2. She so PM to 7:00 AM shift. Sa 2 residents to care for very difficult to keep the them to the bathroom quickly. She stated so through to the mattressong to be changed.  An interview was cone AM with the Activity D was a concern at ever meeting. She reported about staffing to the E She further stated more enough staff and long 3:00 PM to 11:00 PM shifts.  An interview was cone 11/20/14 at 9:00 AM. incontinent episodes is light in time for her to stated she had been I accidents a week that and gown to be change waits during the night very embarrassed who bed.  An interview was cone PM with the DON. He expectation that all caresidents as quickly a reported there were 3 PM to 7:00 AM shift w NA. He stated the nur	stated she worked the 11:00 She reported she has 25 to or during her shift and it was nem clean and dry, help and answer call lights ome residents were soaked as due to having to wait so  ducted on 11/20/14 at 8:45 irector. She stated staffing ry Resident Council d she took the concerns or call light waits were not call light waits were on the and 11:00 PM TO 7:00 AM  ducted with Resident #45 on She stated she did not have f staff answered her call get to the bathroom. She naving 1 to 2 incontinence required her bed sheets ged due to long call light a She further stated she felt en she had accidents in the  ducted on 11/20/14 at 2:30 stated it was his re should be provided to s possible. The DON NAs assigned to the 11:00 with up to 32 residents per ses should be assisting with the DON stated he hired	F	853	3. Measures put in place to ensure the alleged deficient practice does not recur include: In-service education for licensed nurses regarding the proper treatment and care for the administration of intravenous medications and/or fluids, specifically, intermittent infusions of medications or fluids require a tubing set change every 24 hours and the tubing sets should be labeled with the date of initiation. The Director of Nursing and/or the Unit		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345314	B. WING				0
NAME OF B		345514	J D. VVIIVO	0.	TOTAL ADDRESS OF VICTOR TO CORE	1 11/	20/2014
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST O	CITY HEALTH AND REHA	BILITATION CENTER			30 BETHANY CHURCH ROAD		
				_ r	OREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
					Managers will conduct		
F 353	Continued From page		F:	353	care rounds daily for one		e.
1 .		stated he had not addressed with the Resident Council.			week then at least week	ly	
	An interview conducto	ad with Administrator on			for three months to		
		ed with Administrator on evealed she received a			identify that tubing sets		
		esident Council Meeting			for intravenous		
		ressed staffing concerns 014 to inform the residents			medications or fluids ha	ve	
	they were hiring staff.	She further stated she was			been labeled with the		
		complaints related to long incontinence episodes due			appropriate date and		
	to long call light waits.				changed according to		
	residents should not have incontinence episodes				policy. Licensed Nurses		
	due to long call light w				will have a medication		
		admitted to the facility on			pass observation		
	02/11/11 with diagnos	es of hypertension, sease and hemiplegia.			completed at least		
		m Data Set (MDS) dated			annually to include		
		esident #73 was cognitively			intravenous tubing set		
		er revealed Resident #73 Indent for toileting and was			labeling and changing		
	incontinent of bowel a	- 1940 (M. 1941) (M. 1941) (M. 1940) (M. 1940) (M. 1940) (M. 1940) (M. 1940) (M. 1941) (M. 1941) (M. 1941)			according to facility poli	су.	
	Review of the care als	an dated 06/24/14 revealed					
	Resident #73 had boy				4. The Director of Nursing and		
		rventions to provide care			Administrator will review th	e	
	after each incontinent	episode and wear briefs.			results of care rounds and		
		signments from May 2014			medication pass observation	ıs,	
		, 2014 revealed 3 nurse			analyze the data and report		
	aides (NAs) were typically scheduled for the 11:00 PM to 7:00 AM shift and 12 days out of that				patterns/trends to the QAPI		
	[2] [1] - [4] - [	2 NAs scheduled to work			committee every other mon		
	the 11:00 PM to 7:00 A	AIVI SΠΠ.			for 6 months. The QAPI	montriel	
		ent Council Meeting minutes			committee will evaluate the		
	dated 05/2014 through residents had complain	h 11/2014 revealed ints about long call bell wait			effectiveness of the above		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.004				С		
THE PROPERTY OF STREET	New York Continues and the Continues of	345314	B. WING			11/	20/2014	
Magazinesatzi ki	ROVIDER OR SUPPLIER  CITY HEALTH AND REHA	BILITATION CENTER		83	TREET ADDRESS, CITY, STATE, ZIP CODE  30 BETHANY CHURCH ROAD  OREST CITY, NC 28043			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
F 353	times at each meeting minutes revealed a comough staff on the 1 and they had to wait to the enough staff on the 1 and they had to wait to the enough staff on the 1 and they had to wait to the enough and they had to wait to the enough and they had to enough and they had to enough and they are they ar	g. The August 19, 2014 complaint that there was not 1:00 PM to 7:00 AM shift oo long to be changed. contation in the minutes of ong call light wait times or the night shift.  Iducted on 11/20/14 at 6:40 at the tated she worked the 11:00 and B hall and the se stated she had up to 32 at didn't feel like they a needed because of if she was on the accould not see the call lights is had long wait times for ered.  Iducted on 11/20/14 at 6:45 at the tated she worked the 11:00 and it was very difficult to toileted, clean, dry, turned a stated she answered call the could but some residents attress by the time she was	F	353	plan, and will add additional interventions, based on identified outcomes, to ensure continued compliance.  F353  1. Corrective action for the alleged deficient practice for Resident 45, Resident #73, and Resident #47 here been accomplished by providing assistance with toileting and incontinent care in a timely manner Staffing levels have been reviewed and adjusted the provide for care needs of third shift.  2. Residents who require assistance with toileting incontinence care have the potential to be affected by the same alleged deficient practice therefore, the Director of the same alleged deficient practice therefore, the Director of the same alleged deficient practice therefore, the Director of the same alleged deficient practice therefore, the Director of the same alleged deficient practice therefore, the Director of the same alleged deficient practice therefore, the Director of the same alleged deficient practice therefore, the Director of the same alleged deficient practice therefore, the Director of the same alleged deficient practice therefore, the Director of the same alleged deficient practice therefore, the Director of the same alleged deficient practice therefore, the Director of the same alleged deficient practice therefore the deficient practice therefore the deficient practice therefore the deficient practice therefore the deficient practice the deficient practice the deficient practice therefore the deficient practice the deficient practice therefore the deficient practice therefore the deficient practice the deficient pr	ne ce nt nas ch ce . n to on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345314			8000 80000000 400	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WNG_	B. WING			20/2014		
NAME OF PROVIDER OR SUPPLIER  FOREST CITY HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  830 BETHANY CHURCH ROAD  FOREST CITY, NC 28043				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 353	was a concern at ever meeting. She reported about staffing to the E She further stated more enough staff and long 3:00 PM to 11:00 PM shifts.  An interview was come AM with Resident #73 between 45 minutes the answered on the 11:00 nights. He stated here knew he was wet and soon enough the uring the bed. He further stawaited for his light to had a clock on his was an interview was come PM with the DON. He expectation that all caresidents as quickly a reported there were 3 PM to 7:00 AM shift with NA. He stated the nur call lights and care. The NAs as quickly as he positions. He further staffing concerns the staffing staff.	director. She stated staffing by Resident Council of she took the concerns birector of Nursing (DON). The st of the concerns were not goall light waits were on the land 11:00 PM TO 7:00 AM and 11:00 PM TO 7:00 AM and 11:00 PM TO 7:00 AM and 11:00 PM to 7:00 AM most ang his call light because he lift they didn't change him be soaked through his brief to lated he knew how long he light in front of his bed.  In the stated on 11/20/14 at 2:30 stated it was his light to be light of the second	F3	353	Nursing has completed an audit of current residents to identify their toileting/incontinence needs. The Interdisciplinary Team has reviewed Care Grids for the identified residents to ensure the Resident Care Specialists are provided with communication related to toileting/incontinence needs. The Administrator and/or Director of Nursing have evaluated staffing levels based on care needs and made adjustments where necessary. The Social Services Director has completed an audit of current residents who are capable of participating in interviews regarding			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10000000000000000000000000000000000000	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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	DOLUBER OF STREET	345314	D. WING_	OTDEST ADDRESS SITV STATE TIP CODE	11/20/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST (	CITY HEALTH AND REHA	BILITATION CENTER		830 BETHANY CHURCH ROAD		
				FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 353	Continued From page	14	F 3	53		
	to long call light waits residents should not h due to long call wait ti 3. Resident # 47 was	nave incontinence episodes		timely toileting assistance and/or incontinence care.  3. Measures put in place to		
	and hyperlipidemia. Review of the Minimum Data Set dated 09/09/14 indicated Resident #47 was cognitively intact. The MDS further revealed Resident #47 required extensive assistance with toileting and was frequently incontinent of bladder.			ensure the alleged deficient practice does not recur include: In-service education will be conducted for nursing staff regarding the		
	A review of staffing as through November 20 aides (NAs) were typi 11:00 PM to 7:00 AM	47 's care plan revealed in for urinary incontinence. esignments from May 2014 a, 2014 revealed 3 nurse cally scheduled for the shift and 12 days out of that		provision of toileting/incontinence care in a timely manner and maintaining adequate staffing levels to provide for care needs. The		
	time period there were 2 NAs scheduled to work the 11:00 PM to 7:00 AM shift.  A review of the Resident Council Meeting minutes dated 05/2014 through 11/2014 revealed residents had complaints about long call bell wait times at each meeting. The August 19, 2014 minutes revealed a complaint that there was not enough staff on the 11:00 PM to 7:00 AM shift and they had to wait too long to be changed. There was no documentation in the minutes of any action taken for long call light wait times or insufficient staffing on the night shift.  An interview was conducted on 11/20/14 at 6:40 AM with NA #4. She stated she worked the 11:00 PM to 7:00 AM shift on B hall and the Rehabilitation hall. She stated she had up to 32			Division Director of Clinical Services will conduct In-service education for the Director of Nursing and Administrator regarding review of staffing patterns and the provision of care on all shifts. The Director of Nursing or Administrator will review nursing staffing schedules daily, Monday through		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
345314 B. WNG		C 11/20/2014	
	STREET ADDRESS, CITY, STATE, ZIP CODE	11/20/2014	
FOREST CITY HEALTH AND REHABILITATION CENTER	830 BETHANY CHURCH ROAD FOREST CITY, NC 28043		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 353 Continued From page 15 residents per shift and didn't feel like they received the care they needed because of staffing. She reported if she was on the Rehabilitation hall she could not see the call lights on B hall and residents had long wait times for call lights to be answered.  An interview was conducted on 11/20/14 at 6:45 AM with NA #1. She stated she worked the 11:00 PM to 7:00 AM shift and it was very difficult to keep all the residents toileted, clean, dry, turned and repositioned. She stated she answered call lights as quickly as she could but some residents were soaked to the mattress by the time she was able to get to their room.  An interview was conducted on 11/20/14 at 6:50 AM with NA #2. She stated she worked the 11:00 PM to 7:00 AM shift. She reported she has 25 to 32 residents to care for during her shift and it was very difficult to keep them clean and dry, help them to the bathroom and answer call lights quickly. She stated some residents were soaked through to the mattress due to having to wait so long to be changed.  An interview was conducted on 11/20/14 at 8:45 AM with the Activity Director. She stated staffing was a concern at every Resident Council meeting. She reported she took the concerns about staffing to the Director of Nursing (DON). She further stated most of the concerns were not enough staff and long call light waits were on the 3:00 PM to 11:00 PM and 11:00 PM TO 7:00 AM shifts.  An interview was conducted on 11/20/14 at 11:55 AM with Resident #47. She stated she wet herself	Friday, including review of weekend nursing staffing schedules, to ensure that staffing is adequate to provide for the care of residents. The Director of Nursing, Unit Managers, or Social Services Director will conduct interviews with at least 25% of interviewable residents who require toileting assistance or incontinence care to identify concerns related to timely toileting assistance on a monthly basis for three months. Resident Council meetings will include questions regarding timely toileting assistance bi-weekly for 1 month, then monthly for the next 3 months. The		

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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	345314 B. WING					11/	20/2014
	ROVIDER OR SUPPLIER CITY HEALTH AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  830 BETHANY CHURCH ROAD  FOREST CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
F 353	Continued From page 16 call light to help her to the bathroom. She stated the response time is the worst during the night.  An interview was conducted on 11/20/14 at 2:30 PM with the DON. He stated it was his expectation that all care should be provided to residents as quickly as possible. The DON reported there were 3 NAs assigned to the 11:00 PM to 7:00 AM shift with up to 32 residents per NA. He stated the nurses should be assisting with call lights and care. The DON stated he hired NAs as quickly as he could to fill the open positions. He further stated he had not addressed the staffing concerns with the Resident Council.		Fí	F 353  Administrator will review the minutes for concerns and timely response to noted concerns. Care Rounds will be completed by Nursing Administration daily for one week then at least weekly for 3 months to identify concerns with timely toileting assistance to ensure continued compliance.			
F 371 SS=E	11/20/14 at 2:55 PM r copy of the monthly R minutes and had addr with them in August 2 they were hiring staff. not aware resident collight waits or incontine call light wait times. Sishould not have incontong call light wait time 483.35(i) FOOD PROSTORE/PREPARE/SE  The facility must - (1) Procure food from considered satisfactor authorities; and	CURE, ERVE - SANITARY sources approved or y by Federal, State or local tribute and serve food	F	371	the results of care rounds, interviews, Resident Council minutes, and staffing sheets, analyze the data and report patterns and trends to the QAPI committee every other month for six months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions, based on identified outcomes, to ensure continued compliance.		12-18-14

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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		345314	B. WING			11/	20/2014
	ROVIDER OR SUPPLIER	BILITATION CENTER		83	TREET ADDRESS, CITY, STATE, ZIP CODE 30 BETHANY CHURCH ROAD OREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 371	by: Based on observation facility failed to keep to equipment clean and keep 2 plastic contain 2 of 3 ice chests free failed to label and dat nourishment rooms.  The findings included 1. Observations of the 11/17/14 at 10:00 AM problem with stored for Visual inspection of printhe food preparation Food Service Director cook as ready for use inside of 2 of 6 stacker from another stack of debris on the outside 11/17/14 at 10:29AM metal slicer, which was use, revealed a white the entire metal surfauncovered.  Observations on 11/1 blue plastic container the kitchen ice chest. observed to have dar bottom and inside edge.	is not met as evidenced  ans and staff interviews the food preparation service dry when stored; failed to hers used for ice scoops for from black particles; and he stored food in 2 of 2  facility's kitchen on revealed the following bod preparation equipment, hans stored stacked together harea and identified by the har (FSD) and the kitchen har revealed moisture on the hard pans and 1 of 5 pans har pans contained dried food hedge of the pan. On his visual inspection of the has covered and ready for howdery substance over how of the slicer when  7/14 at 10:05 AM revealed a hat held the ice scoop for The container was he black specks on the	F	371	1. Corrective action for the alleged deficient practice has been accomplished washing the identified pans and drying them be arranging separately without stacking. The plastic storage containe for ice scoops were cleaned. The meat slices was cleaned and covere for the next use. Items ithe nourishment rooms were removed and discarded at the time of identification.  2. Facility residents have the potential to be affected the same alleged deficies practice; therefore, the Dietary Services Manage has completed an audit equipment and ice scoopstorage containers to ensure their cleanliness.	e by  y  rs  d  n  by  nt  er  of  p	
	revealed that food sto	orage equipment such as d clean, not wet, and air			New ice scoops with		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	************			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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100 O 170 m 100 O 170 m		345314	B. WNG			PRESENTE AND CORE	11/2	20/2014	
NAME OF P	ROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE ANY CHURCH ROAD			
FOREST (	CITY HEALTH AND REHA	ABILITATION CENTER		-	-	CITY, NC 28043			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 371	that it should be clear FSD specified that the was thickner. Further revealed the container should be checked evand if it needed clean sanitized before storic container.  2. Observation of the 11/17/14 at 10:45 AM opened ice cream stowner opened. An int Nurse #4 who was proom at the time. Shoresponsibility to clear refrigerators and discidated. She said the illabel and date when of the unable of the beverage. Further nourishment room rewith 1/2 inch water and bottom of the contain in the container. An ill was present in the nor revealed dietary staff the nourishment room any food not labeled nurse aides were supcontainers holding the	on for the kitchen slicer was need after each use. The ewhite powdery substance interview with the FSD er which held the ice scoop very day by the kitchen aides ing it should be cleaned and ng the scoop in the  unit A nourishment room on a revealed one quart of ored with no label or date erview was conducted with essent in the nourishment estated dietary staff have in the nourishment room ard any food not labeled or ce cream should have had a opened.  In the state of the state of the order with used by date of all or date when opened on the order with an ice scoop stored on the er with an ice scoop stored on the order of the order of the order with Nurse #4 who ourishment room at the time thave responsibility to clean the refrigerators and discard or dated. She stated that uposed to check the erice scoops and make sure	F	371	3.	internal drainage trays were purchased and are in use. Nourishment rooms have been audited by the Dietary Services Manager to ensure undated, unlabeled, or expired items are not present.  Measures put in place to ensure the alleged deficient practice does not recur include: In-service education for dietary services staff regarding storing, preparing, and distributing food in a sanitary manner, specifically, drying procedures for clean items such as pans; cleaning of ice scoop containers according to a schedule or when soiling is noted; cleaning and storage of kitchen equipment such as meat slicers; and			
	they had been cleaned and sanitized before ice gets passed.					monitoring nourishment rooms for timely discard			

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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		345314	B. WING_	B. WING			20/2014
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 30 BETHANY CHURCH ROAD		
FOREST (	CITY HEALTH AND REHA	ABILITATION CENTER			OREST CITY, NC 28043		
0000W 00W	OLIMINADA OT	ATTINENT OF DEGICIENCIES	ID	_	T		O/F)
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F 371	Continued From page An interview was con- 11/19/14 at 11:10 AM aides had the respons nourishment room ref to discard any unlaba stated the containers nourishment rooms st sanitized by nursing s	ducted with the FSD on  He stated that the dietary sibility of keeping the rigerators clean. They were ed and undated food. He for the ice scoops in the	F	371	[1]		
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CONTINUATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	200 BA - 0		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345314	B. WNG			C	
	ROVIDER OR SUPPLIER		b. Willo	83	TREET ADDRESS, CITY, STATE, ZIP CODE 30 BETHANY CHURCH ROAD OREST CITY, NC 28043	1 11/	20/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	11/19/14 at 11:10 AM aides had the responsion nourishment room ref to discard any unlaba stated the containers nourishment rooms stanitized by nursing stanitized by nursing stanitized.	ducted with the FSD on  He stated that the dietary sibility of keeping the rigerators clean. They were ed and undated food. He for the ice scoops in the	F:	371	months. The QAPI committee will evaluate the effectiveness of the plan and amend the plan based on identified outcomes to ensure continued compliance.  4. The Administrator and Administrator will review the results of cleaning schedules, kitchen sanitation checklists, and nourishment room audits, analyze the data and report trends and patterns to the QAPI committee every other month for 6		

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

Event ID: UCCD11

Facility ID: 923147

If continuation sheet Page 20 of 20

pg 21 this