DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	COM	E SURVEY PLETED
		345526	B. WING _				C / <b>30/2015</b>
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				36	47 MILLER BRIDGE ROAD		
CAROLIN	A REHAB CENTER OF B	URKE		co	ONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 248 SS=D	INTERESTS/NEEDS The facility must prov of activities designed the comprehensive as		F 2	248			4/24/15
	by: Based on observatio record review and sta failed to provide an in for 1 of 3 residents sa (Resident #128). The findings included Resident #128 was a 01/16/15 with diagnos Alzheimer's Disease, placed immediately u infection of clostridium The admission Minim 01/23/15, coded Resi of 15 on the Brief Inte indicating he had sev was also coded as re for bed mobility, trans nonambulatory. The participated in the spe activity preferences. #128 noted newspape activities, being outsid	dmitted to the facility ses of hypertension, difficulty walking, and was nder isolation for the			The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state a federal regulations as outlined. To rem in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center □s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F248 How corrective action will be accomplished for each resident found thave been affected by the deficient practice □ Resident # 128 no longer resides at the facility.	nd nain ig of co e	
	-	e importance of group s favorite activities were			deficient practice. The Administrator or designee will audi	it	
		SUPPLIER REPRESENTATIVE'S SIGNATURE	=		TITLE		(X6) DATE

Electronically Signed

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

04/21/2015

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	. ,	ATE SURVEY MPLETED
		345526	B. WING			С
	ROVIDER OR SUPPLIER	040020		STREET ADDRESS, CITY, STATE, ZI		03/30/2015
				3647 MILLER BRIDGE ROAD	I CODE	
CAROLIN	A REHAB CENTER OF B	BURKE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE & CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 248	Continued From page	<b>a</b> 1	F 24			
1 240			F 24	-	ing racidanta an	
	occupation was blank	The section for previous		current residents, includ isolation, for appropriate	-	
				activity assessments. Re	-	
	Review of the compu	terized medical record		were assessed, reviewe		
		assessment was due on		careplanned, and activiti		
	01/23/15 and had not	t been completed as of		per resident preferences	<ol> <li>Confused and</li> </ol>	
		e no notes or any indication		isolated residents will be	-	
		ment, interests, abilities and		completion and accuracy		
	-	an developed to engage him		assessment for One on	One individual	
	in activities.			activity programs.		
		bserved in his room in bed				
		PM, and 1:27 PM, at 1:43		Measures to be put in pl		
		at 4:12 PM. The only time		changes made to ensure	e practice will not	
	-	gaged in any activity was at description of the second second second second second second second second second s		Re-occur-		
		d 2 visitors at his bedside.		During daily (Mon-Fri) st	and un meetings	
	He was observed on	03/24/15 at 10:03 AM sitting		the activity director or de		
	opposite the nursing	station in his wheelchair and M. Neither time was he		all new activity assessm		
	interacting with anyor	ne. He was in bed on		Based on assessments,	individual	
	03/24/15 at 3:37 PM	not engaged in any activity.		activities will be provided	-	
				on One program. Reside		
		in his room dozing at 9:44		been identified as confus		
		At 10:37 AM on 03/25/15 he		that are on isolation, will		
		e shower room taking a 5 at 11:07 AM he was in his		activities through a One such as television, radio		
		ick to bed. Staff proceeded		and puzzle books.	<b>5</b> , <b>50000</b> , <b>50000</b>	
		requested and he remained				
	in bed asleep at 11:5	•		How facility will monitor	corrective	
				action(s) to ensure defic	ient practice will	
		AM two nurse aides #2 and		not re-occur-		
	#3 proceeded to prov				<b>.</b> .	
		old the surveyor who was		Weekly audits will be pe		
	observing care that R			week for one month and	-	
	-	lent #128 remained in bed		months by MDS for active ensure timely, accurate		
		ing television on 03/26/15 at /l, 10:21 AM, 11:12 AM, and		activity assessments. Re		
	at 12:55 PM.	,,, anu		will be assessed, review		

Facility ID: 970078

If continuation sheet Page 2 of 60

	S FOR MEDICARE &					<u>10. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BOILDING			С
		345526	B. WING		0	3/30/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/00/2010
			3647 MILLER BRIDGE ROAD			
	A REHAB CENTER OF B	URKE		CONNELLY SPG, NC 28612		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 248	Continued From page	2	F 248	3		
	Interview with the Act 03/26/15 at 1:04 PM in completed the assess had just started within in the facility when Res She further stated sho records for Resident as assessment, docume activity participation. not provide activities in isolation and as an all occasions to bring him search. She subseque cognition would not p complete word search isolation, she stated as She further stated that provide activities for m could not provide dood the resident or his pai She further stated that one on one visits inclu #128 as she believed responded well to mu she did not know if Re and if so the type of m generally would start popular for his age gm family to determine pai Interview with the Adm 1:46 PM revealed wh isolation for c-diff, the	ivity Director (AD) on revealed she had not sment. She related that she in the last month and was not esident #128 was admitted. e could not locate any #128 related to any fitter related to any fitter related to any mation of preferences, or She stated that she could to him when he was on ternative she offered on 2 m magazines or word uently confirmed his ermit him to be able to nes. Because he was in she could only talk to him. at she did not normally esidents on isolation. She sumentation of her visits with rticipation during her visits. at her plan was to provide uding music to Resident resident #128 liked music nusic. She also stated she introducing music that was oup. She had not contacted ast preferences.		careplanned, and activities impl per resident preferences. Conf isolated residents will be audite completion and accuracy of act assessment for One on One ind activity programs, with response activities documented during qu review in the medical record. M of results will be reported to Qu Assurance Weekly Risk Manag Meeting X three months and Qu Quality Assurance Meetings X further problem resolution.	used and d for timely ivity dividual es to uarterly onitoring ality ement uarterly	

Facility ID: 970078

If continuation sheet Page 3 of 60

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/29/2015 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345526	B. WING		_		C 30/2015
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				3647 MILLER BRIDGE RO	AD		
CAROLIN	A REHAB CENTER OF B	URKE		CONNELLY SPG, NC 2	8612		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 248	assistance of a nurse activities to assist with because of him being limited in the activities asking family to come On 03/27/15 at 9:58 A sitting opposite the nu- his wheelchair. Durin he had been in the Ko navy. After the navy h National Weather Cer the resident chatted, h talking with him and s have someone to talk The nurse aide (NA) # activities while there v interviewed on 03/27/ revealed that she wor department from Deca ago. She revealed sh obtaining oral historie them to the MDS staff system. She further r interviewed Resident and she could not obt preferences from him being an interim activit family to obtain additio interests as she did no responsibility. She did had been in the milita she was able to ascer that she offered him a with but he did not set	vacant and she enlisted the aide with a background in a activities. She stated that in isolation the staff were a they could offer short of and sit with him. M, Resident #128 was irsing station in the hall in g conversation, he stated orean war as part of the ne was employed at the ther. After the surveyor and ne thanked the surveyor for tated it was "its good to to on a day like this." #1 who assisted with vas no activity staff was 15 at 11:53 AM. NA #1 ked in the activity ember 2014 until a month ne was responsible for s from the residents, gave it to input into the MDS evealed when she #128 he was very confused ain information regarding . She further stated that ity staff, she did not contact onal information related to obt thinks that was her d say that Resident #128 ry but that was about what tain from him. She stated i model airplane to tinker em interested. As a result ould just try to engage him	F 24				
	she was able to ascer that she offered him a with but he did not see she visited him and w	tain from him. She stated model airplane to tinker em interested. As a result					

Facility ID: 970078

If continuation sheet Page 4 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/29/2015 MAPPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345526	B. WING		_		C 30/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE		3647 MILLER BRIDGE RO			
				CONNELLY SPG, NC 2	8612		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 248	F 248 Continued From page 4 about but he often did not engage in		F 24	48			
		rther stated she did not tion with Resident #128.					
F 272 SS=D	worked part time and for the MDS questions preferences. She sta information on the ME findings from the inter any further in relation assessment, care pla she gathered to the a development of an ac	e and revealed that she interviewed Resident #128 s related to activity ted that she filled out the DS form related to her rview but did not proceed to an activity care area n or passing the information ctivity director/staff for tivity plan.	F 2	72			4/24/15
	a comprehensive, acc	luct initially and periodically curate, standardized nent of each resident's					
	resident assessment by the State. The ass least the following: Identification and dem Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior p Psychosocial well-bei	dent's needs, using the instrument (RAI) specified sessment must include at nographic information; atterns; ng; and structural problems;					

Event ID: BX5411

Facility ID: 970078

If continuation sheet Page 5 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(3) DATE SURVEY COMPLETED
		345526	B. WING			C 03/30/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
CAROLIN	A REHAB CENTER OF B	URKE		3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 272	Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments ar Discharge potential; Documentation of sur the additional assess areas triggered by the Data Set (MDS); and	status;	F 2	72		
	by: Based on resident in staff interviews, the fa preferences and abiliti sampled for activities The findings included Resident #128 was a 01/16/15 with diagnos Alzheimer's Disease, placed immediately u infection of clostridium The admission Minim 01/23/15, coded Resi of a possible 15 on th Status indicating he h cognition. He was co	dmitted to the facility on ses of hypertension, difficulty walking, and was nder isolation for the n difficile (c-diff). um Data Set (MDS), dated dent #128 as scoring 00 out le Brief Interview for Mental		F272 How corrective action accomplished for each reside have been affected by the de practice Resident # 128 no longer resident facility How corrective action will be accomplished for those resident the potential to be affected by deficient practice The Activity Director/designed interview all current resident appropriate activity assessment of the residents are unable to questions, the family will be answer questions of resident	ent found to eficient sides at the dents having by the same ee will s for hents. o answer called to	

Event ID: BX5411

Facility ID: 970078

If continuation sheet Page 6 of 60

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-039 ATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· /	B		OMPLETED	
						С	
		345526	B. WING			03/30/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,			
				3647 MILLER BRIDGE ROAD			
CAROLIN	A REHAB CENTER OF E	JURKE	CONNELLY SPG, NC 28612				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE	
F 272	Continued From pag	e 6	F 27	2			
		atory. The MDS noted the	1 27	past/current activity inte	erests The Activity		
		in the specific questions		Director was in-service			
		ferences. Per this MDS,		the Administrator regar			
	Resident #128 noted			constitutes an appropri			
	animals, new activitie	es, being outside and religion		assessment using facil	ity Policy #202		
		ant to him. He offered no		which states patient s			
	response to the ques			and preferences, spiritu			
		activities and doing his		of activities participation			
		re somewhat important. The occupation was blank on the		special needs of the re-	sident.		
	MDS.						
				Measures to be put in p	-		
		iterized medical record		changes made to ensu	re practice will not		
		ctivity assessment was due		Re-occur-			
		not been completed as of		Maaldu y Q maantha du	vina daily atandyn		
		s no Care area Assessment the area of activities for		Weekly x 3 months, du meetings (Mon-Fri) the			
		identified his strengths,		designee will review ne	-		
		s, and whether a care plan		activity assessments for			
	would be developed			timeliness.			
	•			An audit will be perform	ned by MDS on 8		
	Interview with the Ac	tivity Director (AD) on		completed activity asse	essments every		
		revealed she had not		week for one month an	•		
		or other computerized		months to ensure timel	-		
		to activities the facility		completion of activity a			
		that she had just started		How facility will monitor			
		and was not in the facility was admitted. She further		action(s) to ensure defi not re-occur-	cient practice will		
		ate no records for Resident					
		assessment or activity		Results of audit will be	reported to the		
		ated that on occasion she		Quality Assurance Risk	-		
	would contact family	members for information		Committee weekly x th	ree months and		
	related to preference	S.		Quarterly x 1 to the Qu	-		
				Assurance Committee			
		ministrator on 03/26/15 at		continued compliance	or revisions to the		
		nen a resident was on		plan.			
		e resident was not permitted					
		anything. She stated he since admission and was					

Facility ID: 970078

If continuation sheet Page 7 of 60

ATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	10. 0938-039	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CO	MPLETED	
		345526	B. WING			C 3/30/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		0/00/2010	
CAROLIN	A REHAB CENTER OF B	BURKE		3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612			
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 272	Continued From page	e 7	F 2	72			
		recently taken off of isolation, just before the					
		urther stated that from the					
		14 to late February 2015 the on was vacant and she					
		ce of a nurse aide with a					
	background in activiti	ies to assist with activities.					
	The nurse aide (NA)	#1, who assisted with					
		was no activity staff, was					
		/15 at 11:53 AM. NA #1					
	revealed that she wo	rked in the activity ember 2014 until a month					
		he was responsible for					
	obtaining oral historie	es from the residents, gave					
		ff to input into the MDS					
		activities. She further nterviewed Resident #128 he					
		nd she could not obtain					
		preferences from him. She					
		ing an interim activity staff, amily to obtain additional					
		interests as she did not					
		esponsibility. She did say					
		ad been in the military but she was able to ascertain					
		t she visited him and would					
		n in conversation about					
	anything he would tal engage in conversati	lk about but he often did not					
		011.					
		AM, Resident #128 was					
		ursing station in the hall in talking with him, Resident					
		been in the Korean war as					
	part of the navy. Afte	r the navy he was employed					
	at the National Weath	ner Center.					
	On 03/30/15 at 9:45	AM MDS staff #2 was					
		e and revealed that she					

Facility ID: 970078

If continuation sheet Page 8 of 60

STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345526	B. WING			C
	ROVIDER OR SUPPLIER	343320		STREET ADDRESS, CITY, STATE, ZIP C		3/30/2015
	NOVIDER OR OUT LIER			3647 MILLER BRIDGE ROAD		
CAROLIN	A REHAB CENTER OF B	URKE		CONNELLY SPG, NC 28612		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 272	for the MDS question preferences. She sta information on the MI findings from he inter farther in relation to a assessment.	interviewed Resident #128 s related to activity ated that she filled out the DS form related to her view but did not proceed any an activity care area	F 27			
F 278 SS=D	The assessment mus resident's status.	DINATION/CERTIFIED at accurately reflect the ust conduct or coordinate	F 27	8		4/24/15
	participation of health A registered nurse m assessment is compl Each individual who	n professionals. ust sign and certify that the eted. completes a portion of the n and certify the accuracy of				
	willfully and knowingl false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowingl to certify a material a	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money nan \$5,000 for each				
	Clinical disagreemen material and false sta	t does not constitute a atement.				

If continuation sheet Page 9 of 60

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MU	TIPLE CO	ONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, í			· /	PLETED
						С	
		345526	B. WING			03/	/30/2015
NAME OF PR	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	A REHAB CENTER OF B			3647	7 MILLER BRIDGE ROAD		
OAROEIN		JORAL		CO	NNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	e 9	F:	278			
	This REQUIREMENT	⊺ is not met as evidenced					
	Based on record rev facility did not accura			F278 How corrective action will be accomplished for each resident found t	0		
	information on a Minimum Data Set (MDS) assessment for 1 of 1 residents (Resident #126).				have been affected by the deficient practice $\Box$		
	Findings included:				Resident #126 is no longer a resident a the facility.	at	
		dmitted to the facility on					
		ses including altered mental /IDS assessment dated			How corrective action will be	~	
		esident #126's cognitive			accomplished for those residents havin the potential to be affected by the same	-	
	ability was moderatel	•			deficient practice □ MDS was inserviced 4/21/15 on review		
	MDS assessments da	ated 10/14/14 reported that			the Point Click Care- Point of Care repo		
	Resident #126 did no	t demonstrate behaviors.			for C.N.A documentation on behaviors, and the Point Click Care Progress note		
	A staff interview was	conducted with Nurse #2 on			report for behavior notes written by		
	03/27/15 at 3:13 PM.	Nurse #2 reported that			nursing staff.		
		erbally abusive and rude to					
		hat he observed Resident			The MDS Coordinator or designee will	-	
		sive, rude behavior on the			audit current residents as of 04/21/201		
		care for him soon after his uing throughout his stay until			for behaviors, found by running Point C Care Report looking for CNA and Nursi		
	Resident #126 was d				documentation for documented behavio	-	
		conducted with NAs #7 and			MDS will review behaviors during the A		
		27 PM. NAs #7 and #4			period for current residents to ensure the	nat	
		nt #126 frequently made			behaviors are being captured. This	bo	
	unwelcomed commer	desires toward them. They			information will ensure coding is captur based on documented behaviors by	eu	
		nt #126 would grab at their			nursing staff.		
		eir lower abdomens. NA #7					
	and NA #4 verbalized	that the experienced			Measures to be put in place or systemi	с	
		cribed behaviors beginning at			changes made to ensure practice will n	ot	
	the time of his admise throughout his stay u	•			Re-occur:		

Facility ID: 970078

If continuation sheet Page 10 of 60

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· · /	G	· · · ·	MPLETED
						С
		345526	B. WING	······		3/30/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
CAROLIN	A REHAB CENTER OF E	BURKE		3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 278	Continued From page	e 10	F 27	78		
	discharged.			During daily (Mon-Fri) St		
	A staff interview was	conducted and MDS nurse		the MDS Coordinator or review all new MDS s for	•	
		with MDS Nurse #1 on		coding by reviewing the		
		<ol> <li>MDS Nurse #1's notes</li> </ol>		Point of Care report for (		
	recorded that Reside first reported on 10/1	ent #126's behaviors were		documentation on behave Point Click Care Progres		
		lent #126's behaviors should		behaviors written by nur		
		on the MDS assessment		MDS Coordinator will au		
	dated 10/14/14 since 10/10/14.	they were reported to her on		of behaviors daily (Mono weeks, weekly x 2 week		
	10/10/14.			month, and monthly x 1.		
				How facility will monitor action(s) to ensure defic		
				not re-occur-		
				The MDS Coordinator w		
				results of these audits in Assurance Risk Meeting	· ·	
				Quarterly Quality Assura		
				for further problem resol		
F 279 SS=D	483.20(d), 483.20(k) COMPREHENSIVE		F 27	79		4/24/15
		e results of the assessment nd revise the resident's of care.				
	The facility must deve	elop a comprehensive care				
	plan for each residen	ables to meet a resident's				
	-	d mental and psychosocial				
	÷	fied in the comprehensive				
		lescribe the services that are ain or maintain the resident's				

Facility ID: 970078

If continuation sheet Page 11 of 60

		ND HUMAN SERVICES			FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345526	B. WING		C 03/30/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
	A REHAB CENTER OF B			3647 MILLER BRIDGE ROAD	
CAROLIN	A REHAD CENTER OF D	JURKE		CONNELLY SPG, NC 28612	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 279	<ul> <li>F 279 Continued From page 11         <ul> <li>highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</li> </ul> </li> <li>This REQUIREMENT is not met as evidenced by:         <ul> <li>Based on record reviews and staff interviews the facility did not care plan for resident behaviors toward others for 1 of 1 residents (Resident #126).</li> </ul> </li> </ul>		F 2	F279 How corrective actio accomplished for each res have been affected by the practice: Resident #126 no longer a	ident found to deficient
	10/07/14 with diagnost status and delirium. N dated 10/14/14 asses #126's cognition was MDS assessments da Resident #126 did no A review of Resident' time of his discharge revealed that Resident been included in his of A staff interview was 03/27/15 at 3:13 PM.	conducted with Nurse #2 on Nurse #2 reported that		facility. How corrective action will b accomplished for those res the potential to be affected deficient practice □ The MDS Coordinator perf audit on current residents a Behaviors and care-plans y updated to include behavior Measures to be put in plac changes made to ensure p Re-occur- All new admissions and rea be reviewed for behaviors. Nursing/Unit Manager or d	sidents having by the same formed 100% as of 4/21/2015. were be or care plan. e or systemic practice will not admissions will The Director of esignee and
	Resident #126 was v female staff adding th	Nurse #2 reported that erbally abusive and rude to nat he observed Resident isive, rude behavior on the		Nursing/Unit Manager or d MDS Coordinator will revie Click Care- Point of Care n documentation on behavio	ew the Point eport for C.N.A

Facility ID: 970078

If continuation sheet Page 12 of 60

STATEMENT	DF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		345526			C 03/30/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE		3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET	
F 279	first day he provided admission and contin Resident #126 was d A staff interview was #4 on 03/27/15 at 3:2 indicated that Reside unwelcomed comment appearance and his of reported that Resider buttocks or toward the and NA #4 verbalized Resident #126's desc the time of his admiss throughout his stay undischarged. A staff interview was #2 on 03/30/15 at 10: verbalized that he wo behaviors to be care interventions related A staff interview with conducted on 3/30/15 verbalized that Resid have been care plann interventions related unable to produce an care plan meetings co behaviors. A staff interview with conducted on 03/30/1 #1 verbalized that Resid have been discussed	care for him soon after his uing throughout his stay until ischarged. conducted with NAs #7 and t7 PM. NAs #7 and #4 nt #126 frequently made ints concerning their desires toward them. They it #126 would grab at their eir lower abdomens. NA #7 d that they experienced cribed behaviors beginning at sion and continuing ntil Resident #126 was conducted with MDS nurses to 7 AM. MDS Nurse #2 wild expect Resident #126's planned with focuses and to the behaviors. Social Worker (SW) was to the behaviors should hed along with specific to them. The SW ent #126's behaviors should hed along with specific to them. The SW was y documentation related to oncerning Resident #126's MDS Nurse #1 was 15 at 11:48 AM. MDS Nurse esident #126's behaviors her on 10/10/14 and should in a care plan meeting then cuses and interventions	F 279	Point Click Care Progress note rep behavior notes written by nursing This will ensure that MDS and Nur identifying the same residents with behaviors and care planning appropriately. The MDS Coordina audit daily (Monday □ Friday) x 2 weekly x 2 weeks, bimonthly x 1 m and monthly x 1. How facility will monitor corrective action(s) to ensure deficient practi not re-occur- The MDS Coordinator or designed report results of these audits in we Quality Assurance Risk Meetings months and Quarterly Quality Ass Meetings X1 for further problem resolution.	staff. rsing are n tor will weeks, nonth, ce will e will ekly X 3	

Facility ID: 970078

If continuation sheet Page 13 of 60

	OF DEFICIENCIES	MEDICAID SERVICES		CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					с
		345526	B. WING		03/30/2015
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
CAROLIN	A REHAB CENTER OF	BURKE	-	647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 279	confirmed that there plan meeting concer	e 13 was no note related to a care ning Resident #126's is behaviors were not care	F 279		
F 280 SS=D	483.20(d)(3), 483.10	(k)(2) RIGHT TO INING CARE-REVISE CP	F 280		4/24/15
	incompetent or other incapacitated under	the laws of the State, to g care and treatment or			
	within 7 days after the comprehensive assess interdisciplinary team physician, a register for the resident, and disciplines as determ and, to the extent pro- the resident, the resident legal representative;	re plan must be developed the completion of the the system t; prepared by an the transformation of the transformation that includes the attending ted nurse with responsibility other appropriate staff in the transformation of the transformation of the transformation of the transformation of dent's family or the resident's and periodically reviewed the transformation of the transformation of the transformation the transformation of the transformation of the transformation the transformation of the transformation of the transformation the transformation of the transformation of the transformation of the transformation the transformation of the transformation of transformation of the transformation of the transformation of transformation of t			
	by: Based on observation interviews, the faciliting plan interventions for	T is not met as evidenced ons, record review, and staff y failed to update the fall care r 2 of 3 sampled residents esident #128 and #76).		F280 How corrective action will be accomplished for each resident found have been affected by the deficient practice □Resident # 128 no longer resides at the facility. Resident #76 fa interventions have been care planned	11

Event ID: BX5411

Facility ID: 970078

If continuation sheet Page 14 of 60

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/29/2015 RM APPROVED IO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DA	FE SURVEY MPLETED
		345526	B. WING			o	C 3/30/2015
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	A REHAB CENTER OF B	IIBKE		3	647 MILLER BRIDGE ROAD		
CAROLINA	A REHAD CENTER OF D	ORRE		С	ONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From page	e 14	F	280			
F 280	<ol> <li>Resident #128 wa 01/16/15 with diagnos Alzheimer's Disease,</li> <li>The admission Minim 01/23/15 coded Resid cognitively impaired.</li> <li>extensive assistance toileting and was non has having had a fall none since this admiss</li> <li>The Care Area Asses 01/28/15 revealed he primary mode of trans It was noted that he h at his previous facility currently receiving the The care plan establic Resident #128's risk balance and gait prot This care plan had th have no significant in interventions of ensur- free of trip hazards, the participated in activiti activity and strengthe one person assist, he and used wheelchair</li> <li>The nursing notes ref 6:10 AM, 02/19/15 at</li> </ol>	s admitted to the facility on ses of hypertension, and difficulty walking. um Data Set (MDS) dated dent #128 as severly He was coded as needing with bed mobility, transfers, ambulatory. He was coded in the previous 6 months but ssion. sement for falls dated was confused and his sportation was a wheelchair. had a history of multiple falls v. Resident #28 was erapy. shed 01/28/15 addressed for falls related to confusion, blems and history of falls. e goal for the resident to jury from falling and included ring the environment was ne call light was in reach, he es that promote physical ming, he used a walker and e wore appropriate foot wear,	F	280	<ul> <li>How corrective action will be accomplished for those residents have the potential to be affected by the same deficient practice □</li> <li>The Director of Nursing/Unit Manage designee will audit current residents of falls as of 4/20/2015 to determine that interventions are careplanned appropriately.</li> <li>The Director of Nursing re-educated Unit Manager on her role when a fall occurs including care plan revisions, patient monitoring, appropriate referr and communication to staff for all recommendations.</li> <li>This inservice was conducted on 4/22/2015.</li> <li>Measures to be put in place or system changes made to ensure practice will Re-occur:</li> <li>The Unit Manager verifies correct fall interventions are included on each caplan. The Unit Manager is responsible implementing patient monitoring, appropriate referrals, and communication to staff for all recommendations.</li> </ul>	ne r or with t fall the als, nic not	
	PM; and on 03/13/15 indicated that Reside in his wheelchair and	at 10:37 AM. The notes nt #128 had alarms in place			The Director of Nursing/Unit Manage designee will review the 24 Hour Rep and Point Click Care documentation falls to ensure that the appropriate	ort	
		ere in place. Nursing notes			interventions are placed on the care-	plan	

Event ID: BX5411

Facility ID: 970078

If continuation sheet Page 15 of 60

	DEFICIENCIES	MEDICAID SERVICES			ONSTRUCTION	OMB NC	
	CORRECTION	IDENTIFICATION NUMBER:	· ,			1 Y /	LETED
							С
		345526	B. WING			03/	30/2015
NAME OF PF	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612				
(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 SHOUL		3E	(X5) COMPLETIO DATE
F 280	Continued From page	e 15	F 28	80			
		I that family was informed	120		and revise the careplan as necessary.	lf	
		to have an alarmed self			the appropriate interventions are not		
	release seat belt plac				careplanned it will be addressed at the	e	
					time of the audit. The audits will review	v	
		odated to reflect falls which			actual fall careplans daily (Monday		
		, 03/10/15, 03/13/015 and			Friday) x 2 weeks, weekly x 2 weeks, bimonthly x 1 month, and monthly x 1.		
	03/15/15. However, t	and the care plan did not			bimonuniy x i monun, and monuniy x i.		
		terventions of fall mats, or					
	alarms or the self rele				How facility will monitor corrective		
					action(s) to ensure deficient practice w	/ill	
		5 at 1:34 PM with Nurse #4			not re-occur-		
		28 had multiple falls from			<b>—</b>		
	release seat belt on h	ed and now used a self			The results of these audits will be reviewed in weekly Quality Assurance		
					Risk Meetings X 3 months and Quarte	rlv	
	Resident #128 was of	bserved to have a low bed,			Quality Assurance Meetings X1 for fur	•	
	mats on the floor on e	each side of his bed and a			problem resolution.		
	•	n use during observations					
		3:37 PM; on 03/25/15 at					
	11:57 AM, 2:37 PM; c	on 03/26/15 at 5:45 AM.					
	Resident #128 was of	bserved in a high back					
		with anti-tip bars on the front					
		release alarm belt in place					
	when he was observe	ed in his wheelchair on					
	03/25/15 at 9:23 AM, 3:40 PM.	9:54 AM, at 11:07 AM and					
	On 03/26/15 at 6.15 4	AM, Nurse Aide (NA) #2					
		heir information related to					
		needs by word of mouth					
	from the nurse or the	nurse aide leaving the prior					
		I there was a care guide					
		t the nursing station. At this					
		for this resident's hall was					
		as no information located in #128. A different resident					
	name was written in F						

If continuation sheet Page 16 of 60

CENTER STATEMENT (		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			FORM OMB NC (X3) DATE	0: 04/29/2015 MAPPROVED 0: 0938-0391 SURVEY LETED
		345526	B. WING				
		040020				03/	30/2015
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST			
CAROLIN	A REHAB CENTER OF B	URKE		647 MILLER BRIDGE ROA CONNELLY SPG, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	there were instruction located in the point cl	AM the unit manager stated s for nurse aides also ick care computer system	F 280				
	nurse aides to follow interventions of a low side of the bed, a bed alarmed seat belt wer used for Resident #12	ick care information for revealed that the bed, floor mats on each l alarm and a self release re not listed as needing to be					
	of Nursing on 03/26/1 nurse aides can pull t notebook or they can information off the con fall a nurse is to initiat appropriate and place plan. The point click of set up to link the inter reports and the nurse	5 at 1:56 PM revealed that he care guide from the print a list of care guide mputer. At the time of the					
	PM, the Administrator plan did not reflect all #128 should have in p fall floor mats, bed ala release seat belt. Sho interventions implement staff to access the info 2. Resident #76 was diagnoses including h	e further stated that all ented should be listed for					

If continuation sheet Page 17 of 60

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345526	B. WING				C 30/2015
NAME OF P	ROVIDER OR SUPPLIER		•	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE			647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(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)		(X5) COMPLETION DATE
F 280	Continued From page	9 17	F	280			
	Resident #76 had a h confusion, gait and ba hemiparesis. Interver and meet his needs, H encourage to call for a support of extremity in aide in bed mobility, a to assist with identifyin Review of an annual I dated 05/15/14 revea severely impaired cog extensive assistance transfers. The annual had impaired range o lower extremity on on walking did not occur, noted since the previo Review of a Care Are Summary for falls dat Resident #76 was at a confusion, gait and ba hemiparesis. The CA attempts would be ma consistent and he wo optimal safety. Review of a care plan Resident #76 had an related to hypotension continue the intervent monitor for adverse e educate to call for ass consult.	ntions included to anticipate keep call light in reach and assist, left arm tray for in wheelchair, assist bars to and geo mattress with wings ing parameters of bed. Minimum Data Set (MDS) led Resident #76 had gnition and required with bed mobility and I MDS noted Resident #76 f motion of his upper and e side of his body and . In addition, no falls were bus assessment. a Assessment (CAA) ed 05/15/14 revealed risk for falls due to alance problems, and A Summary noted the ade to keep staff and routine uld be care planned for a dated 10/27/14 revealed actual fall with no injury in. Interventions included to ions on the at risk care plan,					

If continuation sheet Page 18 of 60

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345526	B. WING				C 30/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CAROLIN	A REHAB CENTER OF B	URKE			647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	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
F 280	<ul> <li>On 10/11/14 at 1:52 found lying on the floor bolsters were added to the bed.</li> <li>On 10/12/14 at 8:10 found lying on the floor the nurse he lost condi- bed bolsters were cordinates of the nurse he lost condi- bed bolsters were cordinates of the nurse he was trying to Personal alarms were - On 10/26/14 at 8:30 found on the floor new nurse he was trying to Personal alarms were - On 11/10/14 at 4:44 found on the floor new bolsters and bed alarn were implemented on Resident #76 was observations of Resident and foot rests were all observations of Resides at 3:40 PM, 03/25/15 at 8:00 AM revealed as bolsters, mats on the bed and a pressure b An interview with Nur at 1:07 PM revealed I of falls and had person and bed. NA #4 states low position with bilat the floor on each sides An interview the Adminis</li> </ul>	AM Resident #76 was or next to his bed. Bed to define the parameter of AM Resident #76 was or next to his bed. He told trol rolling over in bed. The ntinued as an intervention. AM Resident #76 was of to his bed. He told the orget up to go to the kitchen. AM Resident #76 was of to his bed. He told the orget up to go to the kitchen. AM Resident #76 was of to his bed. The bed m were in place. Falls mats a both sides of his bed. Served on 03/23/15 at 11:00 in his wheelchair wearing a and foot. A seat pad alarm lso noted. Subsequent dent #76 in bed on 03/24/15 at 10:37 AM and 03/26/15 a low bed with bilateral floor on each side of his ed alarm in use. se Aide (NA) #4 at 03/26/15 Resident #76 had a history onal alarms used in his chair ed his bed was kept in the eral bolsters and mats on e of his bed.	F	280			

Facility ID: 970078

If continuation sheet Page 19 of 60

		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345526	B. WING		C 03/30/2015
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
	A REHAB CENTER OF B		:	3647 MILLER BRIDGE ROAD	
CAROLIN	A REHAD CENTER OF D			CONNELLY SPG, NC 28612	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETIC
F 280	Continued From page	e 19	F 280		
F 309 SS=D	to update the residen new interventions tha Administrator explain meeting may not occi and they did not routi care plan during the r stated Resident #76's been updated to inclu and chair alarms, low 483.25 PROVIDE CA HIGHEST WELL BEI Each resident must re provide the necessar or maintain the highe mental, and psychoso	t's care plan to include any it were implemented. The ed the facility's at risk ur until a few days after a fall nely review the resident's meeting. The Administrator is care plan should have ude the bed bolsters, bed v bed, and fall mats. ARE/SERVICES FOR NG ecceive and the facility must y care and services to attain st practicable physical,	F 309		4/24/15
	by: Based on record rev interviews the facility needed antianxiety m residents who reques (Resident #114). The findings included Resident #114 was a rehabilitation services diagnoses including of Review of an admissi	dmitted on 02/12/15 for s after a hospitalization with depression. ion Minimum Data Set		<ul> <li>F309</li> <li>How corrective action will be accomplished for each resident found have been affected by the deficient practice □</li> <li>Resident #114 no longer resides at the facility.</li> <li>How corrective action will be accomplished for those residents have the potential to be affected by the same facility.</li> </ul>	ving
		5 revealed Resident #114		deficient practice □ The DON (Director of Nursing)/Unit	

Event ID: BX5411

Facility ID: 970078

If continuation sheet Page 20 of 60

STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION		10. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,		. ,	MPLETED
						С
		345526	B. WING		0	3/30/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
CAROLIN	A REHAB CENTER OF E	BURKE		3647 MILLER BRIDGE ROAD		
-	-			CONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIOI DATE
F 309	Continued From page	e 20	F 30	9		
				Manager or designee in	terviewed current	
		s orders for March 2015		alert & oriented resident		
		114 was ordered Ativan		needed medications we		
		on) 0.5 mg (milligrams) by rs as needed for anxiety.		other residents verbalize regarding not receiving		
		s as needed for anxiety.		medications timely. Othe		
	During an interview of	on 03/26/15 at 9:07 AM		medication administration		
	-	he had waited two hours for		reviewed to ensure they	received as	
	a dose of his as need	ded Ativan recently but could		needed medications in a	a timely manner.	
		lay. Resident #114 further				
		aited two hours because he		The DON/Unit Manager	-	
		ck. Resident #114 explained rvous and his hands would		re-educate current licen completed by 4/24/2015	•	
	shake and the Ativan			and effectiveness of as		
		t #114 stated he was told the		medications. Any license		
		t as the reason for the delay.		not complete this educa		
		-		removed from the sched	dule until	
	An interview was cor			education is completed.		
		30/15 at 10:22 AM. During				
		ninistrator stated residents				
	administer medicatio	ait two hours for the nurse to				
		view further revealed the		Measures to be put in pl	lace or systemic	
		ot aware of any problems or		changes made to ensure Re-occur-	-	
				The Director of Nursing/		
				designee will interview 1 census of those residen		
				needed medications for	-	
				medication administratio		
				interviews will be condu	cted - daily	
				(Monday 🗆 Friday) x 2 v		
				weeks, bimonthly x 1 mo x 1.	onth, and monthly	
				The Director of Nursing/	-	
				designee will inservice a	-	
	1			nurses in orientation that	a as needed	1

Facility ID: 970078

If continuation sheet Page 21 of 60

		D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/29/2015 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345526	B. WING				C / <b>30/2015</b>
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
CAROLIN	A REHAB CENTER OF B	URKE			647 MILLER BRIDGE ROAD ONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309 F 312 SS=E	daily living receives th	RE PROVIDED FOR		309	medications must be given in a timely manner. How facility will monitor corrective action(s) to ensure deficient practice wint not re-occur- The results of these audits will be reviewed in weekly Quality Assurance Risk Meetings X 3 months and Quarter Quality Assurance Meetings X1 for furt problem resolution.	ſly	4/24/15
	by: Based on observation resident and staff inter provide scheduled sh reviewed for activities #104, #114, and #129 The findings included 1. Resident #104 was	s admitted on 03/01/15 for after a hospitalization with			F312 How corrective action will be accomplished for each resident found t have been affected by the deficient practice □ Resident # 104, #114 no longer reside the facility and #129 has been interview and documentation reflects that the resident has received showers as scheduled.	at	
		on Minimum Data Set 5 revealed Resident #104			How corrective action will be accomplished for those residents havin	ıg	

Facility ID: 970078

If continuation sheet Page 22 of 60

			0.00			0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE S COMPL	
			A. BOILDING		с	
		345526	B. WING			0/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
	A REHAB CENTER OF B			3647 MILLER BRIDGE ROAD		
CAROLIN	A REHAD CENTER OF B	JURNE		CONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIC DATE
F 312	Continued From page	e 22	F 31	12		
	1.0	and required extensive		the potential to be affecte	d by the same	
		fers and one person physical		deficient practice	,	
	assistance with bathi			Current alert and oriented		
				family members were inte		
	-	s shower book revealed		regarding receiving show		
		wers were scheduled for		of Nursing/Unit Manager		
		riday during the 3:00 PM to ew of available shower		re-educate current certifie assistants and licensed n	•	
		esident #104 revealed		completed by 4/24/2015,		
		d as completed on 03/10/15		must be completed as sc		
		artment staff assisted her		documented. If resident r		
	with a shower on 03/			of the facility the certified	nursing	
				assistance must report to	the nurse and	
	-	on 03/25/15 at 9:10 AM		document. The nurse will		
		I her last shower had been		resident and document in		
		ay of the previous week and		record. Any CNA/nurse th		
	she would like a show			complete education will b the schedule until educat		
		ducted with Nurse Aide (NA)				
		:17 PM. NA #12 confirmed				
		ent #104's hall on 03/20/14		Monouros to ha autin -1-	an ar avetemia	
		00 PM to 11:00 PM shift. NA		Measures to be put in pla	-	
	evening or if Residen	ny showers were given that at #104 received her		changes made to ensure Re-occur -		
		n 03/20/15 because she				
		e hall and her coworker		The Director of Nursing/L	Init Manager or	
		ers. The interview further		designee will audit showe		
		e not enough NAs scheduled		that patients received sho	owers as	
	then scheduled show	vers were not given.		scheduled (unless contra		
				refused, or out of facility -		
		Administrator on 03/30/15 at		Friday) x 2 weeks, weekly		
		he expected residents to		bimonthly x 1 month, and	montniy x 1.	
		as scheduled and also inform the nurse if they were		The Director of Nursing/L	Init Manager or	
		an assigned shower during		designee will educate all		
	their shift.			certified nursing assistant	-	
				that showers must be cor		
	During an interview o	on 03/30/15 at 12:05 PM NA		scheduled and document		
		orked on Resident #104's		refuses or is out of the fa		

Facility ID: 970078

If continuation sheet Page 23 of 60

			0.00			3 NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>′</i>			DATE SURVEY COMPLETED
			A. BUILDING	;		С
		345526	B. WING		_	03/30/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE	00,00,2010
				3647 MILLER BRIDGE ROA	١D	
CAROLIN	A REHAB CENTER OF B	SURKE		CONNELLY SPG, NC 28	612	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page	e 23	F 31	2		
	hall on 03/20/14 (Fric	lay) during the 3:00 PM to 13 did not recall assisting			must document this.	
	<ul> <li>#13 stated there were that evening and they to complete all the so have offered resident</li> <li>2. Resident #114 was rehabilitation services diagnoses including of pulmonary disease a</li> <li>Review of an admiss (MDS) dated 02/19/1 was cognitively intact assistance with bathi</li> <li>Review of the facility' Resident #114's show every Wednesday an PM to 11:00 PM shift shower documentation</li> </ul>	as admitted on 02/12/15 for s after a hospitalization with chronic obstructive nd coronary artery disease. ion Minimum Data Set 5 revealed Resident #114 t and required one person ng. 's shower book revealed wers were scheduled for id Saturday during the 3:00 . Review of available		not re-occur- The Director of Nur- designee will audit f received showers a contraindicated, ref daily (Monday □ Fri weekly x 2 weeks, t and monthly x 1. The results of these reviewed in weekly Risk Meetings X 3 r	deficient practice will sing/Unit Manager or to validate that patients is scheduled (unless used, or out of facility - iday) x 2 weeks, bimonthly x 1 month, e audits will be Quality Assurance months and Quarterly Meetings X 1for further	
	Resident #114 stated many showers he ha showered on Wednes #114 further stated he scheduled shower or	on 03/23/15 at 1:20 PM I he did not choose how d a week and was last sday (03/18/15). Resident				
	1:20 PM revealed his flaky particles noted a	dent #114 on 03/23/15 at hair was unclean with white at his hairline and several hair. On 03/24/15 at 11:54				

If continuation sheet Page 24 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/29/2015 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345526	B. WING		_		C 30/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE		3647 MILLER BRIDGE ROA CONNELLY SPG, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	AM Resident #114 sta had observed him sha remained unclean with at his hairline. A subs 03/25/15 at 9:22 AM r unclean with white fla hairline. During an interview of Nurse Aide (NA) #14 Resident #114's hall of during the 3:00 PM to stated she was the or PM until another NA of was not time for show it was very busy again not have time to show passed this information An interview with the 10:24 AM revealed sh receive their showers expected the NAs to in not able to complete a their shift. 3. Resident #129 was diagnoses including a chronic pain, and chro disease. Review of the admisss (MDS) dated 02/26/15 was cognitively intact assistance with transf assistance with bathir Review of the facility's	ated a therapy staff member aving this morning. His hair h white flaky particles noted sequent observation on revealed his hair was ky particles noted at his n 03/27/15 at 12:07 PM confirmed she worked on on 03/21/14 (Saturday) of 11:00 PM shift. NA #14 hly NA for the hall until 5:00 came to help her and there vers. NA #14 further stated in on 03/22/15 and she did ver any residents and had on on to the nurse. Administrator on 03/30/15 at he expected residents to as scheduled and also nform the nurse if they were an assigned shower during s admitted on 02/19/15 with hrthritis, muscle weakness, onic obstructive pulmonary ion Minimum Data Set 5 revealed Resident #129 , required extensive fers, and one person	F 312				

If continuation sheet Page 25 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	0. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	e survey IPleted
		345526	B. WING			03	C 3/30/2015
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE			3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 312	every Tuesday and Fi 11:00 PM shift. The f any shower documen after 03/13/15. During an interview o Resident #129 stated scheduled shower on important to her to ge Resident #129 further was not enough staff 03/24/15. An interview was con- #9 on 03/27/15 at 2:5 NA #9 confirmed she on 03/24/15 during th NA #9 stated initially t the entire facility and but then left. NA #9 fi shower Resident #12	riday during the 3:00 PM to acility was not able to locate tation for Resident #129 n 03/26/15 at 8:13 AM she did not receive her	F	31:	2		
F 323 SS=D	10:24 AM revealed sh receive their showers expected the NAs to in not able to complete a their shift. 483.25(h) FREE OF A HAZARDS/SUPERVI The facility must ensu- environment remains as is possible; and ea	SION/DEVICES are that the resident as free of accident hazards	F	32:	3		4/24/15

Facility ID: 970078

If continuation sheet Page 26 of 60

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/29/2015 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345526	B. WING			C 03/30/2015	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
				36	647 MILLER BRIDGE ROAD		
CAROLIN	A REHAB CENTER OF B	URKE			ONNELLY SPG, NC 28612		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	•	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 323	Continued From page	26	F	323			
	by: Based on record revi facility failed to impler staff the resident was bed without assistance reviewed for accident. The findings included Resident #76 was read diagnoses including h the lower left leg joint, weakness. Review of a care plan Resident #76 had a h confusion, gait and ba hemiparesis. Interver and meet his needs, k encourage to call for a support of extremity in aide in bed mobility, a to assist with identifyin Review of an annual I dated 05/15/14 revea severely impaired cog extensive assistance transfers. The annua had impaired range of lower extremity on on	s (Resident #76). dmitted on 01/11/14 with emiplegia, contractures of hypotension, and muscle dated 04/24/14 revealed igh risk for falls related to alance problems, and ntions included to anticipate keep call light in reach and assist, left arm tray for n wheelchair, assist bars to and geo mattress with wings ng parameters of bed. Winimum Data Set (MDS) led Resident #76 had gnition and required with bed mobility and I MDS noted Resident #76 f motion of his upper and e side of his body and In addition, no falls were			<ul> <li>F323</li> <li>How corrective action will be accomplished for each resident found have been affected by the deficient practice □ Resident #76 fall interventio (bed bolsters, personal alarms to bed chair, and fall mats beside bed) have been implemented.</li> <li>How corrective action will be accomplished for those residents have the potential to be affected by the same deficient practice □</li> <li>The Director of Nursing/Unit Manager designee will audit current residents by observational rounds and verification the number of Nursing or designee will re-educate all licensed nurses and CN on maintaining environment free of accident hazards, adequate supervision prevent accidents and what to do when fall occurs. This was completed by 4/24/2015.</li> <li>Any staff member not completing the re-education will be removed from the schedule until they complete the education.</li> </ul>	ns and ng e or y o ted As on to n a	

Event ID: BX5411

Facility ID: 970078

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
					С	
		345526	B. WING		03/30/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	A REHAB CENTER OF B			3647 MILLER BRIDGE ROAD		
CAROLIN	A REHAD CENTER OF D	JURKE		CONNELLY SPG, NC 28612		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETIO	
F 323	Continued From page	e 27	F 32	3		
. 020	1.0	a Assessment (CAA)	1.52	5		
		ted 05/15/14 revealed				
	Resident #76 was at			Measures to be put in place or sys	stemic	
		alance problems, and		changes made to ensure practice		
	hemiparesis. The CA	A Summary noted the		re-occur-		
		ade to keep staff and routine		The Director of Nursing/Unit Mana		
		uld be care planned for		designee will audit 10% resident of		
	optimal safety.			to ensure that fall interventions if		
	Deview of a core plan	dated 10/27/14 revealed		indicated are implemented by	action	
		n dated 10/27/14 revealed actual fall with no injury		observational rounding with verific (Monday □ Friday) x 2 weeks, we		
		n. Interventions included to		weeks, bimonthly x 1 month, and		
		tions on the at risk care plan,		x 1.	literative	
		effects of medications,		~		
		sistance, and pharmacy		How facility will monitor corrective	•	
	consult.			action(s) to ensure deficient pract not Re-occur-	ice will	
		76's post fall assessments				
		on from 10/2014 through		The results of these audits will be		
	03/2015 revealed the			reviewed in weekly Quality Assura		
		AM Resident #76 had an		Risk Meetings X 3 months and Qu	-	
		was found on the floor next		Quality Assurance Meetings X1 fo	or turther	
		e nurse he was trying to get n. No injuries were noted. A		problem resolution.		
		d on his forehead and he				
	was sent to the hospi					
	Personal alarms were					
		AM Resident #76 had an				
		was found on the floor next				
		polsters and bed alarm were				
	-	f the fall. Falls mats were				
	implemented on both					
		AM Resident #76 had an and was found supine of				
		Resident #76 reported back				
		-ray were completed with no				
		ted. Neurological checks				
		changes were made to the				
	interventions for falls.		1			

If continuation sheet Page 28 of 60

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/29/2015 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345526	B. WING				30/2015
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE			3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
					,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	the nurse aide that Re floor near his bed. He of bed and reported a bolsters were in place nurse noted an abras tears to his left knee a #76 was sent to the h returned to the facility pressure bed alarm w of the fall and she pla Review of a nurse's n Nurse #5 was alerted Resident #76 was lyir He stated he rolled ou Nurse #5 observed an skin tears to his left k Neurological checks w Resident #76 was ser evaluation and return (computerized tomog the hospital was negative to the series to his left was negative the stated he solid	AM the nurse was alerted by esident #76 was lying on the a told the nurse he rolled out headache. The bed a the time of the fall. The ion to his head and skin and right elbow. Resident ospital for an evaluation and the nurse also noted a vas not in place at the time ced one on his bed. ote dated 03/13/15 revealed by the nurse aide that ng on the floor near his bed. ut of bed and hit his head. n abrasion to his head and nee and right elbow. were within normal limits. ht to the hospital for an ed to the facility. A CT raphy) scan performed at titive for head injury. Nurse	F	323	3		
	on Resident #76's ber Resident #76 was obs AM up and dressed in splint on his left leg at and foot rests were al observations of Resid at 3:40 PM, 03/25/15 at 8:00 AM revealed a	alaced a pressure pad alarm d. served on 03/23/15 at 11:00 n his wheelchair wearing a nd foot. A seat pad alarm so noted. Subsequent lent #76 in bed on 03/24/15 at 10:37 AM and 03/26/15 a low bed with bilateral floor on each side of his					
	bed and a pressure b An interview with Nur at 1:07 PM revealed F						

Facility ID: 970078

If continuation sheet Page 29 of 60

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	COMPL	
		345526	B. WING		03/30/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE		3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(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 APPROF DEFICIENCY)	DBE	(X5) COMPLETIO DATE
F 323	low position with bilat the floor on each side An interview was con Administrator on 03/2 interview the Adminis should have had a pro-	ed his bed was kept in the eral bolsters and mats on e of his bed. ducted with the 6/15 at 1:50 PM. During the trator stated Resident #76 essure bed alarm in place taff he was attempting to thout assistance and	F 32	3		
F 328 SS=D	Nurse #5 confirmed s when Resident #76 h Nurse #5 stated she of time and was not awa have a bed alarm or r nurse aide (NA) told h supposed to a pressu one on his bed. The Nurse #5 could not re Resident #76 was su on 03/13/15. 483.25(k) TREATMEN	did not work that hall all the are if he was supposed to not. Nurse #5 recalled a	F 32	8		4/24/15
	proper treatment and special services: Injections; Parenteral and entera	-				

Facility ID: 970078

If continuation sheet Page 30 of 60

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/29/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345526	B. WING		C 03/30/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				3647 MILLER BRIDGE ROAD	
CAROLIN	A REHAB CENTER OF B	JURKE		CONNELLY SPG, NC 28612	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 328	Continued From page	e 30	F 32	18	
	This REQUIREMENT is not met as evidenced by:				
	Based on observation interviews the facility compressed oxygen room for 1 of 1 observed	cylinders in a resident's vation of unsecured cylinders (Resident #269).		F328 How corrective action will b accomplished for each resident for have been affected by the deficie practice □ The administrator and of Nursing removed the compress oxygen cylinders from Resident # room and placed them in the app	ound to nt Director sed 269□s
	Review of the facility policy for Respiratory/Oxygen Equipment effective date of 02/01/15 revealed under Oxygen Cylinder Use was to: - Maintain proper storage, internal transportation			location on 3/23/15 and all staff w inserviced on compressed oxyge cylinders storage and transfers by 4/24/15.	n
	and use of oxygen cy must be kept secure. a. Do not allow oxyg or sustain a blow that b. Tanks must be in	/linders. Oxygen cylinders		How corrective action will be accomplished for those residents the potential to be affected by the deficient practice The Central Supply Coordinator of designee will round to make sure compressed oxygen cylinders are	e same or all
	PM of 1 portable corr with the gauge readir	nade on 03/23/15 at 1:17 npressed oxygen cylinder ng ½ full lying on the end of and 1 portable compressed		appropriately following facility pol 2701 which reads: 1. Maintain proper storage, inte	icy #
	leaned against the wabed side table. Reside room at the time of time of the time of the time of time of time of time of the time of time o	the gauge reading ½ full all in front of Resident #269's lent #269 was not in the ne observation but her #145 was lying in her bed.		transportation and use of oxygen cylinders. Oxygen cylinders must secure. Do not allow oxygen cylir overturned or sustain a blow that break off the top.	be kept nder to be may
	PM with nurse aide # portable compressed	ducted on 03/23/15 at 1:23 4 (NA). She stated the oxygen cylinders should not tesident #269's bed or		<ol> <li>Tanks must be in a cart or si made for the type of tank being u stored in a rack.</li> </ol>	
		all. She stated all full or		Director of Nursing or designee w	vill

Facility ID: 970078

If continuation sheet Page 31 of 60

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLETED
			D. MANO		С
		345526	B. WING		03/30/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 3647 MILLER BRIDGE ROAD	CODE
CAROLIN	A REHAB CENTER OF B	URKE		CONNELLY SPG, NC 28612	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETI O THE APPROPRIATE DATE
F 328	Continued From page	<b>-</b> 31	E 30	28	
F 328	empty oxygen cylinde stand or on the back An observation and ir 03/23/15 at 1:26 PM the Director of Nursin along with the survey oxygen cylinder's in F on the bed and leane Administrator and the cylinder gauges show They further stated it oxygen cylinders to b	ers should be secured in a of the resident's wheelchair. Interview was conducted on with the Administrator and ug (DON). They observed, for, the portable compressed Resident #269's room lying d against the wall. The e DON agreed the oxygen wed both tanks to be half full. was unacceptable for the e unsecured in a resident's ator stated the oxygen	F 32	<ul> <li>re-educate all staff on mastorage, internal transportoxygen cylinders. This we 4/24/2015.</li> <li>Any staff not completing will be removed from the they complete it.</li> <li>Measures to be put in platchanges made to ensure Re-occur-</li> <li>The Central Supply Coord designee will round to mastor compressed oxygen cylina appropriately following fa 2701 pages 153-154. The be documented daily (Mos 2 weeks, weekly x 2 weeks month, and quarterly x 1. weekly x 2 weeks, bimontand monthly x 1.</li> <li>The Director of Nursing/U designee will educate all employees in orientation oxygen cylinders storage</li> <li>How facility will monitor of action(s) to ensure deficinot re-occur-</li> <li>The Director of Nursing of the director of Nursing of the director of Nursing of the director d</li></ul>	tation and use of as completed by this re-education schedule until ace or systemic practice will not dinator or ake sure all nders are secured noility policy # nese rounds will onday □ Friday) x ks, bimonthly x 1 thly x 1 month, Juit Manager or newly hired on compressed and transfers.
	7/02 00) Dravious Versions Obs	relate Event ID-DY5			e audits in weekly /leetings X3

Facility ID: 970078

If continuation sheet Page 32 of 60

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	1° ′	E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED
		345526	B. WING		C 03/30/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	100/2010
CAROLIN	A REHAB CENTER OF B	URKE		3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 328	Continued From page	e 32	F 328	Meetings X 1 for further problem		
F 353 SS=E		NT 24-HR NURSING STAFF	F 353	resolution.		4/24/15
	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.					
	numbers of each of the personnel on a 24-ho	ide services by sufficient ne following types of ur basis to provide nursing n accordance with resident				
	Except when waived section, licensed nurs personnel.	under paragraph (c) of this ses and other nursing				
	section, the facility m	under paragraph (c) of this ust designate a licensed harge nurse on each tour of				
	by: Based on observatio and staff interviews th an as needed antianx sampled residents wh medications (Residen provide scheduled sh reviewed for activities	is not met as evidenced ns, record review, resident ne facility failed to administer siety medication for 1 of 3 no requested as needed nt #114), the facility failed to owers for 3 of 7 residents of daily living (Residents 0) and the facility failed to		F353 How corrective action will b accomplished for each resident fo have been affected by the deficier practice Resident #114, #104, # #154 no longer reside at CROB. T Director of Nursing/Unit Manger o designee have developed new sta patterns by reallocating 2 FTEs to	und to at 260 and he r ffing	

Facility ID: 970078

If continuation sheet Page 33 of 60

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COMPL	LETED
					0	
		345526	B. WING			30/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
CAROLIN	A REHAB CENTER OF E	BURKE		3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 353	Continued From page	e 33	<b></b>	52		
1 000	_	e 33 ble temperatures for 3 of 3	F 3	shift to assure the facility	, has adoquato	
		#242, #260, and #154) due to		nursing staff to provide r		
	insufficient staffing.	12 12, #200, and #10 17 add to		related services to attain		
	5			highest physical, mental		
	The findings included	1:		psychosocial well-being	of each resident.	
				How corrective action wi	ll be	
		s admitted on 02/12/15 for		accomplished for those i		
		s after a hospitalization with		the potential to be affect	ed by the same	
	diagnoses including of	depression.		deficient practice □ The Director of Nursing/	Init Mangar ar	
	Review of an admiss	ion Minimum Data Set		designee will audit staffi		
		5 revealed Resident #114		sheets daily to assure ad		
	was cognitively intact			meet resident needs and		
				assignments according t		
		s orders for March 2015		daily (Monday-Friday) X		
		114 was ordered Ativan		X 2 weeks, bimonthly X	1 month, and	
		on) 0.5 mg (milligrams) by s as needed for anxiety.		Quarterly X 1.		
		s as needed for anxiety.		The Daily Nursing Staffir	ng Summarv	
	A review of staffing a	ssignments from 02/01/15		which lists licensed nurs	• •	
		ealed 3 days with 2 nurses		according to the residen	t census will be	
		to 3:00 PM shift, 1 day with		reviewed daily for each s	-	
		3:00 PM to 11:00 PM shift		or designee to ensure su		
	7:00 AM shift.	rses working the 11:00 PM to		be provided based on cu resident needs.	irrent census and	
	During an interview o	on 03/26/15 at 9:07 AM				
	-	the had waited two hours for				
		ded Ativan recently but could		The Director of Nursing/	Unit Manager or	
	not recall the exact d	ay. Resident #114 further		designee will inservice n	ursing staff to	
		aited two hours because he		address the importance	-	
		ck. Resident #114 explained		of meeting the resident of		
	shake and the Ativan	rvous and his hands would		bathing/showers, serving timely administration of a		
		t #114 stated he was told the		medications. All staff are		
		t as the reason for the delay.		receive this inservice an	-	
				until they do.		
	An interview was con	nducted with the				

Facility ID: 970078

If continuation sheet Page 34 of 60

	S FOR MEDICARE &					NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION	· · /	TE SURVEY MPLETED
		345526	B. WING _			C 3/30/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CAROLIN	A REHAB CENTER OF B	URKE		3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(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 X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 353	Administrator on 03/3 the interview the Adm should not have to wa administer medication requested. The interv Administrator was not concerns regarding m A follow up interview of at 11:04 AM with the A The DON stated if the next shift it was the not find coverage for that coverage was found. the staffing sheets da as needed. The Admi policy was to have 5 of 7:00 AM to 3:00 PM st the 3:00 PM to 11:00 NAs on the 11:00 PM had been short staffer months. 2. Resident #104 was rehabilitation services diagnoses including n Review of an admissi (MDS) dated 03/08/15	20/15 at 10:22 AM. During ainistrator stated residents ait two hours for the nurse to as after they were view further revealed the t aware of any problems or nedication pass. Was conducted on 03/30/15 Administrator and the DON. ere were call outs for the urse on duty responsibility to shift or stay over until She stated she reviewed ily and made adjustments inistrator stated the facility nurses and 8 NAs on the shift, 5 nurses and 8 NAs on PM shift and 3 nurses and 5 to 7:00 AM shift but they d for the past couple of a admitted on 03/01/15 for a after a hospitalization with nuscle weakness. on Minimum Data Set 5 revealed Resident #104	F	<ul> <li>Measures to be put in place changes made to ensure prevent residents and to ensure prevent resident care of Nursing/Ur designee will interview 10<sup>o</sup> census of residents to ider resident care or staffing contrerviews will be conducted (Monday □ Friday) x 2 were weeks, bimonthly x 1 mont x 1.</li> <li>The Director of Nursing/Ur designee will in-service need in orientation to address the and expectations of meeting care needs bathing/shower warm food, and timely adding needed medications.</li> <li>How facility will monitor contre-occurter</li> <li>The results of these audits</li> </ul>	bractice will not hit Manager or % of current httify any brocerns. These ed - daily eks, weekly x 2 th, and monthly hit Manager or we nursing staff he importance ng the resident rs, serving hinistration of as rrective ht practice will will be	
	assistance with transf assistance with bathin A review of staffing as through 03/30/15 reve	and required extensive fers and one person physical ng. ssignments from 02/01/15 ealed 9 days out of that time vorked the 11:00 PM to 7:00		reviewed in weekly Quality Risk Meetings X3 months Quality Assurance Meeting problem resolution.	and Quarterly	

Facility ID: 970078

If continuation sheet Page 35 of 60

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/29/2015 1 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION			LETED
		345526	B. WING		_	( 03/:	_ 30/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE		3647 MILLER BRIDGE ROA CONNELLY SPG, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	every Tuesday and Fi 11:00 PM shift. Revie documentation for Re showers were initialed and the therapy depa with a shower on 03/1 During an interview of Resident #104 stated on Monday or Tuesda she would like a show An interview was com AM with NA #4. She s working with 1 to 2 N/ couple of months. She of the showers done of to the nurse and the r An interview was com AM with NA #15. She staffed and sometime in the building. She st showers done on day working. An interview was com #12 on 03/27/15 at 3: she worked on Reside (Friday) during the 3:0 #12 did not recall if ar evening or if Residem scheduled shower on typically stayed on the completed the showe	vers were scheduled for riday during the 3:00 PM to ew of available shower sident #104 revealed d as completed on 03/10/15 rtment staff assisted her 17/15 (Tuesday). In 03/25/15 at 9:10 AM her last shower had been ay of the previous week and ver more frequently. ducted on 03/25/15 at 9:19 stated they have been As on a hall for the past e stated she cannot get all during her shift and reports it next shift NAs. ducted on 03/25/15 at 12:44 reported the facility is short is there are only 3 to 4 NAs eated it was impossible to get s with only 3 to 4 NAs ducted with Nurse Aide (NA) 17 PM. NA #12 confirmed ent #104's hall on 03/20/14 00 PM to 11:00 PM shift. NA hy showers were given that t #104 received her 03/20/15 because she e hall and her coworker rs. The interview further e not enough NAs scheduled	F 353				

Facility ID: 970078

If continuation sheet Page 36 of 60
CENTER STATEMENT ( AND PLAN OF	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345526	• •	ING _			FORM OMB NC (X3) DATE COMP	): 04/29/2015 MAPPROVED D. 0938-0391 SURVEY LETED C 30/2015
	ROVIDER OR SUPPLIER A REHAB CENTER OF B	URKE		3	STREET ADDRESS, CITY, STATE, ZIP CODE 647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 353	10:24 AM revealed sh receive their showers expected the NAs to i not able to complete a their shift. A follow up interview of at 11:04 AM with the A The DON stated if the next shift it was the nu- find coverage for that coverage was found. the staffing sheets da as needed. The Admi policy was to have 5 m 3:00 PM to 11:00 PM short staffed for the pa During an interview of #13 confirmed she wo hall on 03/20/14 (Frid 11:00 PM shift. NA # Resident #104 with a #13 stated there were that evening and they to complete all the sci have offered residents 3. Resident #114 was rehabilitation services diagnoses including o pulmonary disease ar Review of an admissi (MDS) dated 02/19/15	Administrator on 03/30/15 at the expected residents to as scheduled and also inform the nurse if they were an assigned shower during was conducted on 03/30/15 Administrator and the DON. ere were call outs for the urse on duty responsibility to shift or stay over until She stated she reviewed ily and made adjustments inistrator stated the facility nurses and 8 NAs on the shift but they had been ast couple of months. n 03/30/15 at 12:05 PM NA orked on Resident #104's ay) during the 3:00 PM to 13 did not recall assisting shower that evening. NA e only 6 NAs for the facility would not have been able heduled showers but would s a bed bath. s admitted on 02/12/15 for s after a hospitalization with chronic obstructive nd coronary artery disease. on Minimum Data Set 5 revealed Resident #114 and required one person	F	353				

Facility ID: 970078

If continuation sheet Page 37 of 60

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/29/2015 1 APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345526	B. WING		_		C 30/2015
NAME OF P	ROVIDER OR SUPPLIER		· [	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE		3647 MILLER BRIDGE ROA CONNELLY SPG, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	through 03/30/15 reverse period only 4-5 NAs we AM shift. Review of the facility's Resident #114's show every Wednesday and PM to 11:00 PM shift. shower documentatio revealed showers were 03/04/15, 03/07/15, a During an interview of Resident #114 stated many showers he had showered on Wedness #114 further stated he scheduled shower on was told there were n give showers. Observations of Resid 1:20 PM revealed his flaky particles noted a days ' growth of facia AM Resident #114 states had observed him sha remained unclean wit at his hairline. A subs 03/25/15 at 9:22 AM r unclean with white fla hairline. An interview was conte AM with NA #4. She s working with 1 to 2 NA couple of months. Sho	ssignments from 02/01/15 ealed 9 days out of that time vorked the 11:00 PM to 7:00 a shower book revealed vers were scheduled for d Saturday during the 3:00 Review of available n for Resident #114 re initialed as completed on nd 03/18/15. n 03/23/15 at 1:20 PM he did not choose how d a week and was last iday (03/18/15). Resident e did not receive his Saturday (03/21/15) and ot enough staff working to dent #114 on 03/23/15 at hair was unclean with white it his hairline and several in hair. On 03/24/15 at 11:54 ated a therapy staff member aving this morning. His hair h white flaky particles noted sequent observation on revealed his hair was ky particles noted at his	F 35	3			

Facility ID: 970078

If continuation sheet Page 38 of 60

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/29/2015 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE ( COMPL	SURVEY _ETED
		345526	B. WING			C 03/3	; 30/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
	A REHAB CENTER OF B	IIRKE		3647 MILLER BRIDGE ROAD	)		
OAROEIR				CONNELLY SPG, NC 286	512		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT FICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page	38	F 35	3			
	AM with NA #15. She staffed and sometime in the building. She st showers done on day working. During an interview of Nurse Aide (NA) #14 Resident #114's hall of during the 3:00 PM to stated she was the or PM until another NA of was not time for show it was very busy again not have time to show passed this information An interview with the 10:24 AM revealed sh receive their showers expected the NAs to i not able to complete a their shift. A follow up interview of at 11:04 AM with the A The DON stated if the next shift it was the nu find coverage for that	ducted on 03/25/15 at 12:44 reported the facility is short es there are only 3 to 4 NAs tated it was impossible to get rs with only 3 to 4 NAs n 03/27/15 at 12:07 PM confirmed she worked on on 03/21/14 (Saturday) o 11:00 PM shift. NA #14 hly NA for the hall until 5:00 came to help her and there vers. NA #14 further stated n on 03/22/15 and she did ver any residents and had on on to the nurse. Administrator on 03/30/15 at ne expected residents to as scheduled and also inform the nurse if they were an assigned shower during was conducted on 03/30/15 Administrator and the DON. ere were call outs for the urse on duty responsibility to shift or stay over until She stated she reviewed					
	the staffing sheets da as needed. The Admi policy was to have 5 r 3:00 PM to 11:00 PM short staffed for the pa	ily and made adjustments nistrator stated the facility nurses and 8 NAs on the shift but they had been ast couple of months.					
	4. Resident #129 Was	s admitted on 02/19/15 with					

Facility ID: 970078

If continuation sheet Page 39 of 60

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/29/2015 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE COMP	SURVEY PLETED
		345526	B. WING				C 30/2015
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CAROLIN	A REHAB CENTER OF B	URKE			3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 353	diagnoses including a chronic pain, and chro disease. Review of the admiss (MDS) dated 02/26/13 was cognitively intact assistance with transf assistance with bathin A review of staffing as through 03/30/15 reve period only 4-5 NAs v AM shift. Review of the facility's Resident #129's show every Tuesday and Fi 11:00 PM shift. The f any shower documen after 03/13/15. An interview was con AM with NA #4. She s working with 1 to 2 N/ couple of months. Sh of the showers done of to the nurse and the r An interview was con AM with NA #15. She staffed and sometime in the building. She st showers done on day working. During an interview o Resident #129 stated scheduled shower on	ion Minimum Data Set 5 revealed Resident #129 , required extensive fers, and one person ng. ssignments from 02/01/15 ealed 9 days out of that time worked the 11:00 PM to 7:00 is shower book revealed vers were scheduled for riday during the 3:00 PM to acility was not able to locate tation for Resident #129 ducted on 03/25/15 at 9:19 stated they have been As on a hall for the past e stated she cannot get all during her shift and reports it next shift NAs. ducted on 03/25/15 at 12:44 reported the facility is short is there are only 3 to 4 NAs iated it was impossible to get s with only 3 to 4 NAs	F	353	3		

Facility ID: 970078

If continuation sheet Page 40 of 60

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/29/2015 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345526	B. WING				C 30/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE			647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
0(0)15		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page	e 40	F	353			
		stated she was told there working to give showers on					
	#9 on 03/27/15 at 2:5 NA #9 confirmed she on 03/24/15 during the NA #9 stated initially the the entire facility and a but then left. NA #9 fit shower Resident #129 there was not enough showers.	ducted with Nurse Aide (NA) 9 AM. During the interview worked Resident #129's hall e 3:00 PM to 11:00 PM shift. there were only 4 NAs for someone came in to help urther stated she did not 9 on 03/24/15 because a staff working to provide					
	10:24 AM revealed sh receive their showers expected the NAs to i	Administrator on 03/30/15 at ne expected residents to as scheduled and also nform the nurse if they were an assigned shower during					
	at 11:04 AM with the A The DON stated if the next shift it was the nu find coverage for that coverage was found. the staffing sheets da as needed. The Admi policy was to have 5 m	She stated she reviewed ily and made adjustments nistrator stated the facility nurses and 8 NAs on the shift but they had been					
	01/15/15. Resident # Date Set assessment Resident #242 was co	s admitted to the facility on 242's most recent Minimum dated 02/18/15 indicated ognitively intact, alert and rded Brief Interview for					

Facility ID: 970078

If continuation sheet Page 41 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES			F	ITED: 04/29/2015 ORM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) [	DATE SURVEY OMPLETED
		345526	B. WING			C 03/30/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	 E	
			:	3647 MILLER BRIDGE ROAD		
CAROLIN	A REHAB CENTER OF B	URKE		CONNELLY SPG, NC 28612		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	Mental Status score of A review of staffing a		F 353			
	period there were 4-5 worked the 7:00 AM t of that time period 4-5 PM to 11:00 PM shift period 3 NAs that wor AM shift. During the 3 days with 2 nurses PM shift, 1 day with 1	nurse aides (NAs) that o 3:00 PM shift, 9 days out 5 NAs that worked the 3:00 and 10 days out of that time rked the 11:00 PM to 7:00 same time period there were working the 7:00 AM to 3:00 nurse working the 3:00 PM 5 days with 1-2 nurses				
	on 03/24/15 at 3:40 P the breakfast, lunch a the facility are frequer	ducted with Resident #242 M. Resident #242 reported nd dinner meals served by htly cold. Resident #242 sometimes warm but never				
	Manager (DM) 03/25/ reported that resident concerning cold food. responded to resident temperatures from test being served to reside being served cold. D had discussed the col Administrator and Dir had implemented a ne and cold food compla reported that the reas residents cold is that in the tray carts too lo DM provided tray served	conducted with the Dietary 15 at 12:34 PM. DM s had complained to her DM verbalized that she t complaints by taking food at trays at the time food is ents and confirmed food is M also verbalized that she ld food complaints with the ector of Nursing (DON) and ew system of passing trays ints continued. The DM on food is being served to the trays sit on the hallways ing prior to being served. vice audits which recorded im test trays and resident				

Facility ID: 970078

If continuation sheet Page 42 of 60

CENTER STATEMENT (		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	FORM OMB NC (X3) DATE	D: 04/29/2015 MAPPROVED D. 0938-0391 SURVEY PLETED
		345526	B. WING				C 30/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE			3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	service audits recorded food sometimes cold of notation of 1 nurse aid the other NA answerin arrived on hall 5:21 Pl 6:15 PM. The DM log the DM spoke with NA resident complaints of test tray evaluation will being served cold and trays to serve and onl DM tray service audit residents complained with trays arriving on 1 tray served at 1:40 PN 03/03/15 recorded witf food being served col from a resident who v good if it didn't sit on the During an observation 03/25/15 at 1:20 PM the NAs were primarily re trays and other staff in NAs to pass trays. A staff interview was of AM with NA #7. She m staffing levels it is offer serve meal trays befor A staff interview was of 03/27/15 at 10:34 AM hard to get the food tr are only 6 NAs working that any need to respond emergencies makes in	cold food. The DM's tray ed resident complaints of on 01/12/15 with the de (NA) passing trays and ng resident's call lights; trays M with last tray served at g dated 02/05/15 indicated As on 200 hall concerning f cold food and conducted a hich revealed food was d noted that there were 20 ly one NA to pass trays. The dated 03/02/15 noted that food was being served cold hall at 1:00 PM with the last M. Tray service audit dated th resident complaints of d along with a comment verbalized the food would be the hallway so long. In of meal trays being passed the DM indicated that the esponsible to pass meal nembers seldom assist the conducted 03/27/15 at 9:45 reported that due to low en difficult for the staff to ore they get cold. conducted with NA #6 I. She verbalized that it's rays served hot when there ng in the facility and added	F	353			

Facility ID: 970078

If continuation sheet Page 43 of 60

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345526	B. WING				C / <b>30/2015</b>
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE			3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	<ul> <li>with passing meal trait A staff interview was a Administrator and DO They verbalized their served to residents be temperature. They co discussed residents be them and that the DM system of passing trait residents from being a A follow up interview 03/30/11:04 AM with the DON. The DON state the next shift it was the responsibility to find a over until coverage w reviewed the staffing adjustments as needed the facility policy was on the 7:00 AM to 3:00 NAs on the 3:00 PM the nurses and 5 NAs on shift but they had bee couple of months. The stated residents should ue to staffing.</li> <li>6. Resident #260 was rehabilitation services An interview was contor on 03/23/15. Resider oriented with no memory of the staff or th</li></ul>	er than NAs seldom assist ys to residents. conducted with N on 3/27/15 at 3:45 PM. expectation was that food e at a palatable eating nfirmed that the DM had being served cold food with I had implemented a new ys in an effort to prevent served cold food. Was conducted on the Administrator and the d if there were call outs for ree nurse on duty coverage for that shift or stay as found. She stated she sheets daily and made ed. The Administrator stated to have 5 nurses and 8 NAs 0 PM shift, 5 nurses and 8 o 11:00 PM to 7:00 AM in short staffed for the past e Administrator further Id not be receiving cold food s admitted to the facility for a on 03/06/15. ducted with Resident #260 nt #260 was alert and ory problems noted. During t # 260 stated he ate in his	F	353	3		
		he had complained about					

Facility ID: 970078

If continuation sheet Page 44 of 60

PRINTED: 04/29/2015

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 04/29/2015 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345526	B. WING			C / <b>30/2015</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	A REHAB CENTER OF B			3647 MILLER BRIDGE ROAD		
CAROLIN	A REHAD CENTER OF D	URRE		CONNELLY SPG, NC 28612		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	A follow up interview of Resident #260 while h his breakfast on 03/26 #260 stated his break morning and commen meals were served bas A review of staffing as through 03/30/15 reve period there were 4-5 worked the 7:00 AM to of that time period 4-5 PM to 11:00 PM shift period 3 NAs that wor	but it did not do any good. was conducted with he was eating his breakfast 5/15 at 8:48 AM. Resident fast was barely warm this hed that most all of his arely warm. ssignments from 02/01/15 ealed 7 days out of that time nurse aides (NAs) that o 3:00 PM shift, 9 days out 5 NAs that worked the 3:00 and 10 days out of that time rked the 11:00 PM to 7:00	F 353	3		
	3 days with 2 nurses of PM shift, 1 day with 1 to 11:00 PM shift and working the 11:00 PM A staff interview was of Manager (DM) 03/25/ reported that resident concerning cold food. responded to resident temperatures from test being served to resident being served to reside being served to reside being served to reside being served to reside to reside the cold Administrator and Dire had implemented a ne and cold food compla reported that the reas residents cold is that fi in the tray carts too lo DM provided tray served	conducted with the Dietary				

Facility ID: 970078

If continuation sheet Page 45 of 60

		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/29/2015 // APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION		LETED
		345526	B. WING				C 30/2015
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE			3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 353	service audits recorde food sometimes cold notation of 1 nurse aid the other NA answerin arrived on hall 5:21 P 6:15 PM. The DM log the DM spoke with NA resident complaints o test tray evaluation wi being served cold and trays to serve and on DM tray service audit residents complained with trays arriving on tray served at 1:40 Pf 03/03/15 recorded wit food being served col from a resident who v good if it didn't sit on During an observation 03/25/15 at 1:20 PM to NAs were primarily re trays and other staff m NAs to pass trays. Di 03/27/15 at 12:07 AM the NAs were response trays and there were when she worked. Na food trays was often of and answering call be aware of cold food co she would warm up re asked her to.	cold food. The DM's tray ed resident complaints of on 01/12/15 with the de (NA) passing trays and ng resident's call lights; trays M with last tray served at g dated 02/05/15 indicated As on 200 hall concerning f cold food and conducted a hich revealed food was d noted that there were 20 y one NA to pass trays. The dated 03/02/15 noted that food was being served cold hall at 1:00 PM with the last M. Tray service audit dated th resident complaints of d along with a comment erbalized the food would be the hallway so long.	F	353	3		

Facility ID: 970078

If continuation sheet Page 46 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/29/2015 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345526	B. WING		_		C 30/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE		3647 MILLER BRIDGE ROA CONNELLY SPG, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	She further indicated caused the delay in p hall. An interview with the J 3:45 PM revealed she to the residents at pal Administrator stated t discussed recent cold implemented a new s to the halls to prevent served cold food. A follow up interview at 11:04 AM with the J The DON stated if the next shift it was the nu find coverage for that coverage was found. the staffing sheets da as needed. The Admi policy was to have 5 m 7:00 AM to 3:00 PM s the 3:00 PM to 11:00 NAs on the 11:00 PM had been short staffer months. The Administ residents should not b staffing. 7. Resident #154 was 11/10/14. The most quarterly dated 02/25 15 out of 15 on the Bi Status indicating she	possible with less than 6. that answering call bells assing the trays out on the Administrator on 03/27/15 at e expected food to be served atable temperatures. The he Dietary Manager had food concerns and had ystem of food cart delivery residents from being was conducted on 03/30/15 Administrator and the DON. ere were call outs for the urse on duty responsibility to shift or stay over until She stated she reviewed ily and made adjustments nistrator stated the facility hurses and 8 NAs on the shift, 5 nurses and 8 NAs on PM shift and 3 nurses and 5 to 7:00 AM shift but they d for the past couple of	F 353				

If continuation sheet Page 47 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 04/29/2015 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		345526	B. WING			C / <b>30/2015</b>
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZI		
	A REHAB CENTER OF B		3	647 MILLER BRIDGE ROAD		
CAROLIN	A REHAD CENTER OF D	UKKL	c	ONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE	(X5) COMPLETION DATE
F 353	period there were 4-5 worked the 7:00 AM t of that time period 4-5 PM to 11:00 PM shift period 3 NAs that wor AM shift. During the 3 days with 2 nurses PM shift, 1 day with 1 to 11:00 PM shift and working the 11:00 PM On 03/24/15 at 9:46 A that the food could be heat in the microwave further stated she has food. On 03/25/15 at 9:25 A finished breakfast. Si French toast and bac the breakfast meal was breakfast was cold ev stated that she had co she has complained a reheated it. She cont to be on hall 200 and breakfast as always of were always lukewarr A staff interview was Manager (DM) 03/25/ reported that resident concerning cold food. responded to residen temperatures from tes being served cold. D had discussed the co	in urse aides (NAs) that o 3:00 PM shift, 9 days out 5 NAs that worked the 3:00 and 10 days out of that time rked the 11:00 PM to 7:00 same time period there were working the 7:00 AM to 3:00 nurse working the 3:00 PM 5 days with 1-2 nurses 1 to 7:00 AM shift. AM, Resident #154 stated e hotter and the staff will e if you ask them. She s gotten used to eating cold AM, Resident #154 had just he stated that she had on. She further stated that as too cold and that very day. Resident #154 omplained before and when about the cold food, staff tinued stating that she used there she described the cold and the other meals m. conducted with the Dietary	F 353			

Facility ID: 970078

If continuation sheet Page 48 of 60

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/29/2015 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345526	B. WING				C 30/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
				30	647 MILLER BRIDGE ROAD		
CAROLIN	A REHAB CENTER OF B	URKE		С	CONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	and cold food complair reported that the reast residents cold is that it in the tray carts too lo DM provided tray serve food temperatures fro- complaints related to service audits recorded food sometimes cold notation of 1 nurse aid the other NA answerin arrived on hall 5:21 P 6:15 PM. The DM log the DM spoke with NA resident complaints of test tray evaluation will being served cold and trays to serve and onl DM tray service audit residents complained with trays arriving on tray served at 1:40 PM 03/03/15 recorded witf food being served col from a resident who vi good if it didn't sit on the During an observation 03/25/15 at 1:20 PM to NAs were primarily re trays and other staff in NAs to pass trays.	ew system of passing trays ints continued. The DM on food is being served to the trays sit on the hallways ng prior to being served. vice audits which recorded m test trays and resident cold food. The DM's tray ed resident complaints of on 01/12/15 with the de (NA) passing trays and ng resident's call lights; trays M with last tray served at dated 02/05/15 indicated As on 200 hall concerning f cold food and conducted a nich revealed food was a noted that there were 20 y one NA to pass trays. The dated 03/02/15 noted that food was being served cold hall at 1:00 PM with the last <i>A</i> . Tray service audit dated h resident complaints of d along with a comment erbalized the food would be the hallway so long.	F	353	DEFICIENCY)		
	residents before the f	NA was assigned to pass					

Facility ID: 970078

If continuation sheet Page 49 of 60

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 04/29/2015 1 APPROVED 2: 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
		345526	B. WING		_	C 03/30/2015		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
CAROLIN	A REHAB CENTER OF B	URKE		3647 MILLER BRIDGE ROA				
				CONNELLY SPG, NC 28				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 353	Continued From page	2 49	F 35	3				
	32 breakfast trays this	s date.						
	stated during interview the food trays served nurse aides in the bui with less than 6. She answering call bells c the trays out on the ha An interview with the 3:45 PM revealed she to the residents at pal Administrator stated t discussed recent cold	aused the delay in passing all. Administrator on 03/27/15 at e expected food to be served atable temperatures. The he Dietary Manager had I food concerns and had ystem of food cart delivery						
F 360 SS=D	at 11:04 AM with the A The DON stated if the next shift it was the ne find coverage for that coverage was found. the staffing sheets da as needed. The Admi policy was to have 5 m 7:00 AM to 3:00 PM st the 3:00 PM to 11:00 NAs on the 11:00 PM had been short staffer months. The Administ residents should not b staffing.	was conducted on 03/30/15 Administrator and the DON. ere were call outs for the urse on duty responsibility to shift or stay over until She stated she reviewed ily and made adjustments nistrator stated the facility hurses and 8 NAs on the shift, 5 nurses and 8 NAs on PM shift and 3 nurses and 5 to 7:00 AM shift but they d for the past couple of trator further stated be receiving cold food due to IET MEETS NEEDS OF	F 36				4/24/15	

If continuation sheet Page 50 of 60

TATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		ONSTRUCTION	(X3) [	NO. 0938-039 DATE SURVEY COMPLETED
		0.45500					С
		345526	B. WING				03/30/2015
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF E	BURKE			7 MILLER BRIDGE ROAD		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIOI DATE
F 360	Continued From page 50 The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.		F3	360			
	by: Based on observation resident and staff inter provide a bag lunch f dialysis three times a	☐ is not met as evidenced ons, record review and erviews the facility failed to for 1 of 1 resident receiving week (Resident #269).			F360 How corrective action will be accomplished for each resident fo have been affected by the deficien practice	und to	
	03/04/15 with diagno diabetes. The admiss (MDS) dated 03/04/1	dmitted to the facility on ses of renal failure and sion Minimum Data Set 5 revealed Resident #269 t. The MDS further stated			Resident # 269 has and will contin have a bagged lunch provided by facility three times a week while re dialysis. Dietary staff is hand deliv bagged lunch to patient prior to he dialysis treatment.	the eceiving /ering	
	#269 had the potentia related to renal and r sugars diet restriction Interventions includer resident the importan ordered. Encourage t Explain consequence obesity/malnutrition r	d explain and reinforce to the ice of maintaining the diet the resident to comply. es of refusal, isk factors. Provide, serve itor intake and record every			How corrective action will be accomplished for those residents I the potential to be affected by the deficient practice The Dietary Manager &/or Registe Dietitian or designee will audit all o residents receiving dialysis to ensi lunches are provided to residents receiving dialysis.	same er current	
	An observation was r AM of Resident #269 Administrator at the 1 dialysis. Resident #20			The Dietary Manager and/or desig educate facility staff regarding the importance or providing each resid with a nourishing, well balanced d meet the needs of each resident.	dent iet to		

Facility ID: 970078

TATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>'</i>	PLE CONSTRUCTION	(X3) DATE SURV COMPLETED	
			A. BUILDING	3	C	-
		345526	B. WING		03/30/20	015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
CAROLIN	A REHAB CENTER OF B	URKE		3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE CON TO THE APPROPRIATE	(X5) IPLETION DATE
F 360	AM with Resident #20 dialysis 3 days a wee Saturday from 12:00 member takes her. R facility had never offe she went to dialysis of She stated she was r bag lunch from the fa stated she and her fa restaurant on the way nice to have a bag lun always have money t An interview was con AM with nurse aide (f not know if Resident a dialysis. NA #4 stated dialysis with her famil ready and to the car w An interview was con AM with Resident #20 received a lunch tray send a bag lunch with An interview was con AM with the Administ transporter/driver that should have gone to lunch for Resident #22 she was unaware that taking her to dialysis	ducted on 03/25/15 at 9:30 69. She stated she goes to ek, Tuesday, Thursday and PM to 4:00 PM and a family esident #269 stated the ered to bring her a tray before or send a bag lunch with her. not aware she could take a icility with her to dialysis. She imily member ate at a local y to dialysis but it would be nch because they didn't to eat. ducted on 03/26/15 at 11:16 NA) #4. She stated she did #269 took a bag lunch to d Resident #269 went to ly member and he got her without help from the staff. ducted on 03/26/15 at 11:25 69. She stated she had not and no one had offered to n her to dialysis.	F 36	<ul> <li>education will be completed and staff not receiving the be removed from the science receive the education.</li> <li>Measures to be put in pletchanges made to ensure Re-occur-</li> <li>All new admissions and be reviewed for offsite deto ensure bag lunches at to residents that receive Dietary Manager &amp;/or Redesignee will review new re-admission alerts to ere dialysis residents are reallunch when scheduled for audits will be performed 2weeks and bi-monthly monthly x 2months.</li> <li>How facility will monitor action(s) to ensure deficient not re-occur-</li> <li>Dietary Manager &amp;/or Redesignee will report the audits in Weekly Quality Meetings x3 months and Assurance Meetings x 1 problem resolution.</li> </ul>	his education will hedule until they lace or systemic e practice will not re-admissions will ialysis treatments ire being provided dialysis. The egister Dietitian or w admission and hsure that all ceiving a bag or dialysis. These daily (Mon-Fri) x x1 month and corrective cient practice will egister Dietitian or results of these Assurance Risk d quarterly Quality	
	An interview was con	ducted on 03/26/15 at 1:08				

Facility ID: 970078

If continuation sheet Page 52 of 60

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345526	B. WING				C 30/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE			647 MILLER BRIDGE ROAD ONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 360 F 364 SS=D	PM with the Dietary M resident 's that receive bag lunch to dialysis a when they returned fr kitchen made up bag transporter/driver that came to the kitchen to the resident. The DM Resident #269's famil dialysis and she wasr take with her. She fur would start taking Res her before she left for A follow up interview w Administrator on 03/2 stated the bag lunch g discussed with Reside and a bag lunch shou with Resident #269 w one. 483.35(d)(1)-(2) NUT PALATABLE/PREFEF Each resident receive food prepared by met value, flavor, and app palatable, attractive, a temperature. This REQUIREMENT by: Based on observatio interviews with staff a failed to serve food at	Anager, (DM). She stated ve dialysis were sent with a and received their lunch tray om dialysis. She stated the lunches daily and the took the resident to dialysis o pick up the bag lunch for stated she was unaware y member took her to of receiving a bag lunch to ther stated the kitchen staff sident #269's bag lunch to dialysis. was conducted with the 7/15 at 10:24 AM. She process should have been ent #269 upon admission Id have been sent to dialysis ithout her having to ask for RITIVE VALUE/APPEAR, R TEMP as and the facility provides hods that conserve nutritive earance; and food that is		360	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state a		4/24/15

Facility ID: 970078

If continuation sheet Page 53 of 60

PRINTED: 04/29/2015

TATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	LE CONSTRUCTION	(X3) D	NO. 0938-039 ATE SURVEY OMPLETED
	CONTRECTION		A. BUILDING			C
		345526	B. WING			03/30/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
				3647 MILLER BRIDGE ROAD		
CARULIN	A REHAB CENTER OF B	BURKE		CONNELLY SPG, NC 28612		
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 364	Continued From page	e 53	F 36	4		
1 001	Findings included:		1 30	federal regulations as outline	d To remain	
				in compliance with all federal		
	1. Resident #242 wa	is admitted to the facility on		regulations the center has tak		
		242's most recent Minimum		take the actions set forth in th		
	Date Set assessmen	t dated 02/18/15 indicated		plan of correction. The follow	ving plan of	
		ognitively intact, alert and		correction constitutes the cer		
		orded Brief Interview for		allegation of compliance. All	-	
	Mental Status score	of 15.		deficiencies cited have been		
		duated with Desident #242		completed by the dates indica	ated.	
		iducted with Resident #242		F364 How corrective action w	uill bo	
		PM. Resident #242 reported and dinner meals served by		accomplished for each reside		
		ntly cold. Resident #242		have been affected by the de		
	•	s sometimes warm but never		practice		
	hot.			F		
		conducted with the Dietary		Resident # 154 & 260 no long	ger reside at	
		/15 at 12:34 PM. DM		Carolina Rehab Center of Bu		
		ts had complained to her		Resident #242 has been inter		
		. DM verbalized that she		documentation reflecting that		
	-	t complaints by taking food		food temperatures have impr	oved.	
		st trays at the time food is ents and confirmed food is				
	-	M also verbalized that she		How corrective action will be		
	-	ld food complaints with the		accomplished for those reside	ents having	
		rector of Nursing (DON) and		the potential to be affected by	-	
		ew system of passing trays		deficient practice	, ,	
	and cold food compla	aints continued. The DM				
	reported that the reas	son food is being served to		The Dietary Manager & Admi	inistrator	
		the trays sit on the hallways		have educated dietary staff o	-	
		ong prior to being served.		of heat on demand system, p	•	
		vice audits which recorded		system, food temperatures, n	•	
	-	om test trays and resident		schedule and dining room pro		
	-	cold food. The DM's tray ed resident complaints of		Dietary Manager &/or Registed designee will perform tray set		
	food sometimes cold			to validate food temperatures		
		ide (NA) passing trays and		receiving meals in their room		
		ng resident's call lights; trays		will be performed three times		
		PM with last tray served at		two weeks; weekly for two we		

Facility ID: 970078

DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 / X / / / / / / / / / /				
		. ,		CONSTRUCTION	1 Y	E SURVEY IPLETED
		A. BUILDING	G			С
	345526	B. WING				3/30/2015
VIDER OR SUPPLIER					1 0.	5/50/2015
REHAB CENTER OF B	URKE		С	ONNELLY SPG, NC 28612		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG				(X5) COMPLETIO DATE
Continued From page	Σ <b>Ε</b> Λ	E 20	~			
		F 30	04	hi monthly y one monthly and monthly y		
					C	
-	-			one monai.		
•				Measures to be put in place or system	ic	
rays to serve and onl	y one NA to pass trays. The			changes made to ensure practice will r	not	
-				Re-occur-		
•						
					nd	
-	-					
	•				to	
-	-					
	the nativary conorig.			-		
During an observatior	n of meal trays being passed			-		
					(	
NAs were primarily re	sponsible to pass meal			one month.		
rays and other staff n	nembers seldom assist the					
NAs to pass trays.						
				-		
					rill	
	•			not re-occur-		
				The Diotony Manager 8 /or Degister		
serve medi udys pelo						
A staff interview was o	conducted with NA #6					
					als	
				in their rooms. These are will be		
•	-			performed three times a week for two		
				•	nly x	
emergencies makes i	t impossible for the NAs to			one month; and monthly x one month.		
				The results of these audits will be		
-						
with passing meal tray	ys to residents.					
A _1_ff :=1 '					for	
				Turtner problem resolution.		
	SUMMARY STJ (EACH DEFICIENC) REGULATORY OR L Continued From page 3:15 PM. The DM log the DM spoke with N/ resident complaints o test tray evaluation with ceing served cold and trays to serve and onl DM tray service audit residents complained with trays arriving on tray served at 1:40 Pf D3/03/15 recorded with food being served cold from a resident who v good if it didn't sit on the During an observation D2/25/15 at 1:20 PM the NAs were primarily re- trays and other staff in NAs to pass trays. A staff interview was of AM with NA #7. She in staffing levels it is offer serve meal trays befor A staff interview was of D3/27/15 at 10:34 AM hard to get the food tr are only 6 NAs working that any need to respi- temergencies makes in serve the residents for reported that staff oth with passing meal trays	REHAB CENTER OF BURKE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 54 3:15 PM. The DM log dated 02/05/15 indicated the DM spoke with NAs on 200 hall concerning resident complaints of cold food and conducted a test tray evaluation which revealed food was being served cold and noted that there were 20 trays to serve and only one NA to pass trays. The DM tray service audit dated 03/02/15 noted that residents complained food was being served cold with trays arriving on hall at 1:00 PM with the last tray served at 1:40 PM. Tray service audit dated 03/03/15 recorded with resident complaints of food being served cold along with a comment from a resident who verbalized the food would be good if it didn't sit on the hallway so long. During an observation of meal trays being passed 03/25/15 at 1:20 PM the DM indicated that the NAs were primarily responsible to pass meal trays and other staff members seldom assist the	REHAB CENTER OF BURKE       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG         Continued From page 54       F 3         S15 PM. The DM log dated 02/05/15 indicated the DM spoke with NAs on 200 hall concerning resident complaints of cold food and conducted a test tray evaluation which revealed food was being served cold and noted that there were 20 trays to serve and only one NA to pass trays. The DM tray service audit dated 03/02/15 noted that residents complained food was being served cold with trays arriving on hall at 1:00 PM with the last tray served at 1:40 PM. Tray service audit dated 03/03/15 recorded with resident complaints of food being served cold along with a comment from a resident who verbalized the food would be good if it didn't sit on the hallway so long.         During an observation of meal trays being passed 03/25/15 at 1:20 PM the DM indicated that the NAs were primarily responsible to pass meal rays and other staff members seldom assist the VAs to pass trays.         A staff interview was conducted 03/27/15 at 9:45 AM with NA #7. She reported that due to low staffing levels it is often difficult for the staff to serve meal trays before they get cold.         A staff interview was conducted with NA #6 03/27/15 at 10:34 AM. She verbalized that it's nard to get the food trays served hot when there are only 6 NAs working in the facility and added that any need to respond to call bells or serve the residents food while it's hot. NA #6 reported that staff other than NAs seldom assist with passing meal trays to residents.         A staff interview was conducted with Administrator and DON on 3/27/15 at 3:45 PM.	REHAB CENTER OF BURKE       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       IP         Continued From page 54       F 364         S:15 PM. The DM log dated 02/05/15 indicated the DM spoke with NAs on 200 hall concerning resident complaints of cold food and conducted a test tray evaluation which revealed food was being served cold and noted that there were 20 rays to serve and only one NA to pass trays. The DM tray service audit dated 03/02/15 noted that residents complained food was being served cold with trays arriving on hall at 1:00 PM with the last ray served at 1:40 PM. Tray service audit dated 03/03/15 recorded with resident complaints of food being served cold along with a comment from a resident who verbalized the food would be good if it didn't sit on the hallway so long.         During an observation of meal trays being passed 03/25/15 at 1:20 PM the DM indicated that the VAs were primarily responsible to pass meal rays and other staff members seldom assist the VAs to pass trays.         A staff interview was conducted 03/27/15 at 9:45 AM with NA #7. She reported that due to low staffing levels it is often difficult for the staff to serve meal trays before they get cold.         A staff interview was conducted with NA #6 03/27/15 at 10:34 AM. She verbalized that it's hard to get the food trays served hot when three are only 6 NAs working in the facility and added that any need to respond to call bells or serve the residents food while it's hot. NA #6 reported that staff other than NAs seldom assist with passing meal trays to residents.         A staff interview was conducted with Administrator and DON on 3/27/15 at 3:45 PM.	BAGE CENTER OF BURKE         Display Set 7 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REDULATORY OR LSC DENTIFYING INFORMATION)         PREVIDERS FLAG. OF CORRECTIVE ACTION SHOULD B PREVIDERS FLAG. OF CORRECTIVE ACTION SHOULD B PREVIDENT	BetAB CENTER OF BURKE         3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         IP         PROVIDE SECTION (EACH ODRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)           Continued From page 54         F 364         bi-monthly x one month; and monthly x one month.           Solid and noted that there were 20 rays to serve and only one NA to pass trays. The DM tray service audit dated 03/02/15 noted that esidents complianed food was being served cold with trays earving on hall at 1:00 PM with the last fray served at 1:40 PM. Tray service audit dated 03/02/15 noted that esidents complianed food was being served cold with trays arriving on hall at 1:00 PM with the last fray served at 1:40 PM. Tray service audit dated 03/02/15 at 1:20 PM the DM indicated that the VAs were primarily responsible to pass meal rays and other staff members seldom assist the VAs were primarily responsible to pass meal rays and other staff members seldom assist the VAs to pass trays.         How facility will monitor corrective action(s) to ensure deficient practice will not re-occur.           A staff interview was conducted 03/27/15 at 9:45 MM with NA #7. She reported that due to low staffing levels it is often difficult for the staff to serve meal trays before they get cold.         How facility will monitor corrective action(s) to ensure deficient practice will not re-occur.           A staff interview was conducted with Astaff interview was conducted with NA #6 opported that staff other than NA \$6 operiod that staff other than NA \$6 operiod that staff other than NA \$6 operiod that staff other than NA \$6 operind that staff other than NA \$6 operiod that staff other

Facility ID: 970078

If continuation sheet Page 55 of 60

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/29/2015 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345526	B. WING		_		C 30/2015
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			3	647 MILLER BRIDGE RO	AD		
CAROLIN	A REHAB CENTER OF B	URKE	c	CONNELLY SPG, NC 2	8612		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 364	discussed residents b them and that the DM system of passing tra residents from being s 2. Resident #260 war rehabilitation services An interview was com on 03/23/15. Resider oriented with no mem the interview Residen room and his food wa Resident #260 stated the cold food to staff th A follow up interview was Resident #260 while th his breakfast on 03/26 #260 stated his break morning and commer meals were served ba A staff interview was of Manager (DM) 03/25/ reported that resident concerning cold food. responded to resident temperatures from tes being served cold. D had discussed the col Administrator and Dir had implemented a no and cold food compla reported that the reas residents cold is that	e at a palatable eating nfirmed that the DM had being served cold food with I had implemented a new ys in an effort to prevent served cold food. s admitted to the facility for a on 03/06/15. ducted with Resident #260 nt #260 was alert and bory problems noted. During it # 260 stated he ate in his is cold at every meal. he had complained about bout it did not do any good. was conducted with he was eating his breakfast 6/15 at 8:48 AM. Resident fast was barely warm this arely warm. conducted with the Dietary	F 364				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/29/2015 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		SURVEY PLETED
		345526	B. WING				/30/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF B	URKE			647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 364	food temperatures fro complaints related to service audits recorde food sometimes cold notation of 1 nurse aid the other NA answerin arrived on hall 5:21 P 6:15 PM. The DM log the DM spoke with NA resident complaints o test tray evaluation with being served cold and trays to serve and onl DM tray service audit residents complained with trays arriving on tray served at 1:40 Pf 03/03/15 recorded wit food being served col from a resident who vi good if it didn't sit on the During an observation 03/25/15 at 1:20 PM to NAs were primarily re trays and other staff in NAs to pass trays. During an interview of Nurse Aide (NA) #14 responsible for passir were usually 2 NAs for NA #14 explained past delayed due to reside bells. NA #14 noted s	vice audits which recorded om test trays and resident cold food. The DM's tray ed resident complaints of on 01/12/15 with the de (NA) passing trays and ng resident's call lights; trays M with last tray served at g dated 02/05/15 indicated As on 200 hall concerning f cold food and conducted a hich revealed food was d noted that there were 20 ly one NA to pass trays. The dated 03/02/15 noted that food was being served cold hall at 1:00 PM with the last M. Tray service audit dated th resident complaints of d along with a comment verbalized the food would be the hallway so long. In of meal trays being passed the DM indicated that the esponsible to pass meal nembers seldom assist the on 03/27/15 at 12:07 AM stated the NAs were ng the food trays and there or the hall when she worked. ssing food trays was often ent care and answering call she was aware of cold food lents and she would warm	F	364			

Facility ID: 970078

If continuation sheet Page 57 of 60

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345526	B. WING				C 30/2015
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CAROLIN	A REHAB CENTER OF B	URKE			3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 364	On 03/27/15 at 10:34 interview that it was d served hot when there building and it was im She further indicated caused the delay in p hall. An interview with the a 3:45 PM revealed she to the residents at pal Administrator stated t discussed recent cold implemented a new s to the halls to prevent served cold food. 3. Resident #154 was 11/10/14. The most recent Minii dated 02/25/15 coded 15 on the Brief Intervi indicating she was co On 03/24/15 at 9:46 A that the food could be heat in the microwave further stated she has food. On 03/25/15 at 9:25 A finished breakfast. Sh french toast and baco the breakfast meal was breakfast was cold ev stated that she had co she has complained a reheated it. She cont	AM NA #6 stated during lifficult to get the food trays e was only 6 NAs in the possible with less than 6. that answering call bells assing the trays out on the Administrator on 03/27/15 at e expected food to be served latable temperatures. The he Dietary Manager had I food concerns and had ystem of food cart delivery t residents from being admitted to the facility on mum Data Set a quarterly d her as scoring a 15 out of ew for Mental Status gnitively intact. AM, Resident #154 stated e hotter and the staff will e if you ask them. She s gotten used to eating cold AM, Resident #154 had just he stated that she had on. She further stated that	F	364	4		

If continuation sheet Page 58 of 60

PRINTED: 04/29/2015

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938 (X3) DATE SURVE	
		IDENTIFICATION NUMBER:	· /		(X3) DATE SURVE COMPLETED	
			A. BUILDING	3		
		345526	B. WING		C	
		545526			03/30/201	15
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	UE	
CAROLIN	A REHAB CENTER OF E	BURKE		3647 MILLER BRIDGE ROAD		
				CONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMP IE APPROPRIATE D	(X5) PLETION DATE
F 364	Continued From pag	e 58	F 36	4		
		cold and the other meals	1 30			
	were always lukewar					
	A staff interview was conducted with the Dietary					
		/15 at 12:34 PM. DM				
	reported that residen	ts had complained to her				
		. DM verbalized that she				
		nt complaints by taking food				
		est trays at the time food is				
	-	lents and confirmed food is				
		M also verbalized that she old food complaints with the				
		rector of Nursing (DON) and				
		new system of passing trays				
		aints continued. The DM				
		son food is being served to				
	residents cold is that	the trays sit on the hallways				
	in the tray carts too le	ong prior to being served.				
		vice audits which recorded				
	-	om test trays and resident				
	-	cold food. The DM's tray				
		ed resident complaints of				
		on 01/12/15 with the				
		ide (NA) passing trays and ing resident's call lights; trays				
		PM with last tray served at				
		g dated 02/05/15 indicated				
		As on 200 hall concerning				
		of cold food and conducted a				
	-	hich revealed food was				
	-	d noted that there were 20				
	-	lly one NA to pass trays. The				
	-	t dated 03/02/15 noted that				
	-	d food was being served cold				
		hall at 1:00 PM with the last				
		M. Tray service audit dated				
03/0						
		ith resident complaints of Id along with a comment				

Facility ID: 970078

If continuation sheet Page 59 of 60

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/29/2015 APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345526	B. WING		_		C 30/2015
NAME OF PI	ROVIDER OR SUPPLIER		_ <b>_</b>	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	A REHAB CENTER OF B			3647 MILLER BRIDGE ROA	D		
CARULIN	A REMAD CENTER OF D	UKKE		CONNELLY SPG, NC 28	612		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 364	Continued From page good if it didn't sit on t During an observation 03/25/15 at 1:20 PM t NAs were primarily re trays and other staff in NAs to pass trays. On 03/27/15 at 9:45 A stated that staffing lev staff to be able to pas residents before the for verbalized that only 1 32 breakfast trays this On 03/27/15 at 10:34 stated during interview the food trays served nurse aides in the bui with less than 6. She answering call bells ca the trays out on the ha An interview with the A 3:45 PM revealed she to the residents at pal Administrator stated the discussed recent cold	<ul> <li>59</li> <li>the hallway so long.</li> <li>a of meal trays being passed he DM indicated that the sponsible to pass meal nembers seldom assist the</li> <li>AM, Nurse Aide (NA) #7</li> <li>vels resulted in difficulty for s the food trays to the bod got cold. She further NA was assigned to pass a date.</li> <li>AM, Nurse Aide (NA) #6 w that it was difficult to get hot when there was only 6 lding and it was impossible further indicated that aused the delay in passing all.</li> <li>Administrator on 03/27/15 at e expected food to be served atable temperatures. The he Dietary Manager had food concerns and had ystem of food cart delivery</li> </ul>	F 36	D			

Facility ID: 970078

If continuation sheet Page 60 of 60

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

CENTERS FOR	R MEDICARE & MEDICAID SERVICES			"A" FORM			
STATEMENT OF	ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY			
NO HARM WITH	ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:			
FOR SNFs AND NFs		345526	B. WING	3/30/2015			
NAME OF PROVI	DER OR SLIDDI IER	STREET ADDRESS,	CITY, STATE, ZIP CODE	· ·			
NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF BURKE		3647 MILLER BRIDGE ROAD CONNELLY SPG, NC					
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES						
F 159	483.10(c)(2)-(5) FACILITY MANAGEMEN	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS					
	Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs $(c)(3)$ -(8) of this section.						
	The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)						
	The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.						
	The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.						
	The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.						
	The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.						
	The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.						
	This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to notify a resident that his personal funds account exceeded the \$1,800.00 Medicaid limit for three months for 1 of 1 sampled resident (Resident #1) and provide cognitively intact residents with a quarterly personal funds account statement for 2 of 2 sampled residents reviewed for personal funds (Resident #1 and #72).						
	The findings included:						
	1. Resident #1 was admitted on 07/22/14 for rehabilitation services with diagnoses including muscle weakness and acute on chronic respiratory failure. Review of a quarterly Minimum Data Set (MDS) dated						

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

The above isolated deficiencies pose no actual harm to the residents

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

CENTERS F	FOR MEDICARE & MEDICAID SERVICES	_		"A" FORM			
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY			
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs			A. BUILDING:	COMPLETE:			
		345526	B. WING	3/30/2015			
NAME OF PR	OVIDER OR SUPPLIER		CITY, STATE, ZIP CODE				
CAROLINA REHAB CENTER OF BURKE		3647 MILLER B CONNELLY SP					
ID		l					
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCI	ENCIES					
F 159	Continued From Page 1 01/21/15 revealed Resident #1 was cogniti	velv intact					
	01/21/15 revealed Resident #1 was cogniti	01/21/15 revealed Resident #1 was cognitively intact.					
	During an interview on 03/23/15 at 12:25 PM Resident #1 stated the facility did not let him know how much money he had in his personal funds account and did not provide him with a quarterly personal funds statement.						
	An interview was conducted with the facility's Accounts Payable Representative on 03/27/15 at 9:53 AM. The Accounts Payable Representative stated Resident #1 was admitted with Medicare and was assisted with filing for Medicare. The interview further revealed his Medicaid benefits went into effect on 11/05/14.						
	Review of Resident #1's quarterly personal funds account statement dated 12/31/14 revealed a closing balance of \$2,893.05.						
	An interview was conducted with the Regional Business Office Consultant by phone on 03/27/15 at 10:01 AM. During the interview the Regional Business Office Consultant confirmed Resident #1's Medicaid benefits went into effect on 11/05/14. He further stated residents' personal funds accounts were audited monthly and if they had a balance approaching \$1,500.00 dollars the resident or responsible party were contacted. At the conclusion of the interview the Regional Business Office Consultant stated he would review Resident #1's personal funds account transactions from November of 2014 through March of 2015 and discuss his findings later in the day.						
	An interview with the Business Office Manager (BMO) on 03/27/15 at 10:12 AM revealed she had been in this position for two months and could not recall what her trainer had told her about any requirements on account balance for a resident on Medicaid. The BMO further stated her trainer and the Regional Business Office Consultant and were currently responsible for auditing resident account balances.						
	During a follow up interview on 03/27/15 Resident #1's personal funds account had a further revealed Resident #1's personal fun 2014, January 2015, and February 2015. T previous BMO would have reviewed Resid statements and Regional Account Specialis statements. The Regional Business Office been noted during the monthly audits begin confirmed no action had been taken since a funding.	a current balance \$2,8 ids account balance v The Regional Busines dent #1's November a st would have review Consultant stated the nning on 12/15/14.	867.58 dollars as of 03/19/15. The intervi vas \$2,800.00 dollars or over in Decembe ss Office Consultant further stated the fac and December of 2014 personal funds acc ed the January and February of 2015 mor e overage in Resident #1's account should The Regional Business Office Consultant	r of ility's ounts nthly			

031099

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

031099

	FOR MEDICARE & MEDICAID SERVICES			"A" FOF			
STATEMENT (	OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY			
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs			A. BUILDING:	COMPLETE:			
		345526	B. WING	3/30/2015			
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDRESS, G	CITY, STATE, ZIP CODE				
CAROLINA REHAB CENTER OF BURKE			3647 MILLER BRIDGE ROAD				
	1	CONNELLY SPO	J, NC				
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCE	CIES					
F 159	Continued From Page 2						
	-	A follow up interview was conducted with Resident #1 on 03/27/15 at 2:38 PM. Resident #1 stated it concerned him that he could have lost his money or Medicaid funding due to an error in the business office.					
	2. Resident #1 was admitted on 07/22/14 for rehabilitation services with diagnoses including muscle weakness and acute on chronic respiratory failure. Review of a quarterly Minimum Data Set (MDS) dated 01/21/15 revealed Resident #1 was cognitively intact.						
	During an interview on 03/23/15 at 12:25 PM Resident #1 stated the facility did not let him know how much money he had in his personal funds account and did not provide him with a quarterly personal funds statement.						
	An interview was conducted with the facility's Accounts Payable Representative on 03/27/15 at 9:53 AM. The Accounts Payable Representative stated the facility 's corporate office was responsible for sending out the quarterly personal funds statements to the residents or their responsible party. Resident #1's quarterly personal funds account statement dated 12/31/14 was reviewed during the interview and revealed he was listed as his own responsible party. The interview further revealed the address on his statement was a former facility.						
	An interview was conducted with the Regional Business Office Consultant by phone on 03/27/15 at 10:01 AM. The Regional Business Office Consultant stated if the resident was their own responsible party they should receive a copy of their quarterly personal funds account statement. The Regional Business Office Consultant reviewed Resident #1's quarterly personal fund statement account dated 12/31/14 during the interview and confirmed the quarterly personal funds statement should have gone straight to him because he was his own responsible party.						
	An interview with the Admissions Director on 03/27/15 at 10:30 AM revealed Resident #1 signed his admission agreement as his own responsible party. The interview further revealed the Admissions Director put the address in the computer for correspondence from the facility but was not involved with the resident funds account.						
	During an interview on 03/30/15 at 10:35 receive a copy of their quarterly personal		r stated cognitively intact residents should ent.				

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

CENTERS FO	NT OF HEALTH AND HUMAN SERVICES OR MEDICARE & MEDICAID SERVICES			A "A" FOR		
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY		
		345526	A. BUILDING:B. WING	COMPLETE: <b>3/30/2015</b>		
NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF BURKE		3647 MILLER BE	STREET ADDRESS, CITY, STATE, ZIP CODE 3647 MILLER BRIDGE ROAD CONNELLY SPG, NC			
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN	ICIES				
F 159	Continued From Page 3					
	3. Resident #72 was admitted on 06/08/11 with diagnoses including chronic obstructive pulmonary disease and heart failure. Review of a quarterly Minimum Data Set (MDS) dated 02/18/15 revealed Resident #72 was cognitively intact.					
	During an interview on 03/23/15 at 3:15 PM Resident #72 stated the facility did not let her know how much money she had in her personal funds account and did not provide her with a quarterly personal funds statement.					
	An interview was conducted with the facility's Accounts Payable Representative on 03/27/15 at 9:53 AM. The Accounts Payable Representative stated the facility's corporate office was responsible for sending out the quarterly personal funds account statements to the residents or their responsible party. Resident #72's quarterly personal funds account statement dated 12/31/14 was reviewed during the interview and revealed she was listed as her own responsible party. The Accounts Payable Representative thought the address on the statement was for a family member.					
	An interview was conducted with the Regional Business Office Consultant by phone on 03/27/15 at 10:01 AM. The Regional Business Office Consultant stated if the resident was their own responsible party they should receive a copy of their quarterly personal funds account statement. The Regional Business Office Consultant reviewed Resident #72's quarterly personal funds account statement dated 12/31/14 during the interview and confirmed she should receive a copy of her quarterly personal funds statement because she was her own responsible party. The Regional Business Office Consultant further stated Resident #72's quarterly personal funds statement further stated Resident #72's quarterly personal funds statement because she was her own responsible party. The Regional Business Office Consultant further stated Resident #72's quarterly personal funds statement was probably going to her family.					
	An interview with the Admissions Director on 03/27/15 at 10:30 AM revealed Resident #72 signed her admission agreement as her own responsible party. The interview further revealed the Admissions Director put the address in the computer for correspondence from the facility but was not involved with the resident funds account.					
	During an interview on 03/30/15 at 10:3 receive a copy of their quarterly persona		stated cognitively intact residents should nt.	I		

#### F 514 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FO	OR MEDICARE & MEDICAID SERVICES			"A" FO		
STATEMENT O	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY		
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs			A. BUILDING:	COMPLETE:		
		345526	B. WING	3/30/2015		
NAME OF PRO	VIDER OR SUPPLIER	STREET ADDRESS,	CITY, STATE, ZIP CODE	I		
CAROLINA REHAB CENTER OF BURKE		3647 MILLER B				
		CONNELLY SPG, NC				
ID PREFIX						
TAG	SUMMARY STATEMENT OF DEFICIEN	CIES				
F 514	Continued From Page 4					
	The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.					
	This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to document new skin tears and treatment in the medical record of 1 of 3 residents sampled for skin integrity issues. (Resident #261).					
	The findings included:					
	Resident #261 was admitted to the facility on 03/21/15. His diagnoses included a fall at home, seizure activity, hypertension, diabetes, and status post below knee amputation.					
	The undated center admission alert form (information obtained by the admission nurse from hospital personnel) noted fragile skin and bruising and a skin tear to left arm.					
	The initial nursing assessment dated 03/21/15 identified the old surgical scar from his above knee amputation. No other skin issues were identified on the assessment nor on the initial nursing note dated 03/21/15 at 2:58 PM.					
	On 03/23/15 at 11:18 AM and at 3:27 PM, Resident #261 was observed with a bandage on his left forearm. In addition his skin was observed to be thin and a large scab across his left forearm.					
	The physician's history and physical dated 03/23/15 noted multiple excoriations and ecchymosis, but no other details about the resident's skin.					
	On 03/25/15 at 9:17 AM Resident #261 was observed being set up for breakfast. He had a large gauze wrapping around his right hand covering the top of his hand up to his wrist. The surveyor also noted a bandage on his right outer shin close to his knee and blood dripping from an area below the dressing.					
	Review of the medical record including nursing notes and treatment records revealed nothing related to any treatments or dressings for Resident #261.					
	On 03/25/15 at 9:21 AM Nurse #2 who was working on the hall stated he normally did not work this hall and the area was there when he arrived. He stated he was told the area on his hand was an old area that just reopened. On 03/25/15 at 10:28 AM, Resident #261 was observed in therapy with a bandage wrapped up his right leg/shin area and a bandage wrapped around his right hand. His hand remained bandaged when observed on 03/26/15 at 6:17 AM.					
	Interview with the nurse aide #5 on 03/26/15 at 10:08 AM revealed Resident #261 was admitted late on her					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY		
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM			A. BUILDING:	COMPLETE:		
FOR SNFs AND NFs		345526	B. WING	3/30/2015		
NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF BURKE		3647 MILLER B	STREET ADDRESS, CITY, STATE, ZIP CODE 3647 MILLER BRIDGE ROAD CONNELLY SPG, NC			
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC	TIES				
F 514	Continued From Page 5					
-		shift and that he came with multiple skin tears. She stated it was her understanding that his hand bandage was a bruise that he had on admission that reopened.				
	On 03/26/15 at 1:00 PM Nurse #3 stated this was only the second day she had worked with Resident #261. She stated she was informed that he hit his hand propelling his wheelchair. She stated that was what she learned when 3rd shift reported off. Nurse #3 reviewed the medical record and confirmed there were no skin assessments or documentation that Resident #261 had any skin tears or skin integrity issues assessed on admission. She further stated that she would have documented the scattered skin tears but would not have measured or staged anything that was not opened. On 03/26/15 at 2:17 PM the Director of Nursing (DON) and Administrator were interviewed. They stated					
	that the initial nursing assessment included a wound assessment. Both confirmed that there should be some documentation of the bruises and skin tears observed on a resident upon admission. The DON stated staff were expected to complete a wound assessment and incident report for any new skin tear. If there was a treatment implemented that should be documented on the treatment record.					
	The first notation of any skin issues related to Resident #261's hand was a incident note in the progress notes dated $03/26/15$ at 5:01 PM that stated on $03/23/15$ therapy brought the resident to the nurse and stated he scratched his hand and it was bleeding. The nurse was noted to clean the area with normal saline and cover it with a Band-Aid.					
	On 03/27/15 at 9:33 AM, Resident #261 had no dressing or wrapping on his right hand. there was a large blood red bruise noted to his outer hand.					

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