	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED MB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(3) DATE SURVEY COMPLETED
		345380	B. WING		C 11/20/2015
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	
				1601 PURDUE DRIVE	
THE REH	AB AND HC CTR AT VILL	AGE GR		FAYETTEVILLE, NC 28304	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=D	HIGHEST WELL BEIL Each resident must re provide the necessary or maintain the higher mental, and psychoso	NG eceive and the facility must y care and services to attain st practicable physical,	F 30	9	12/18/15
	by: Based on observatio interviews, the facility wound care to 1 of 1 whose dressings wer soiled with urine and care. Findings include Resident #18 was re- 05/28/14. Cumulative peripheral vascular di right hip and knee, co and pressure ulcers. Resident #18's care p onset of 05/14/15 of to breakdown related to incontinence. On 06/ a stage 3 to the right the right great toe plat The most recent Qua (MDS) assessment of #18 had severely imp and required extensiv activities of daily living	admitted to the facility on e diagnoses included sease, contractures of the ontractures of the left hand blan identified a problem with being at risk for skin impaired bed mobility and 08/15 a problem with having toe dorsal and a stage 3 to ntar aspect was identified. rterly Minimum Data Set f 1105/15 indicated Resident aired decision making skills re to total assistance with all g. The resident was		F 309 - 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 1) Actions taken for Resident #18 include the following: A. On 11/19/2015, resident □s identified wound areas were re-assessed by the treatment nurse for the presence of any increased deterioration of wound/wound bed to which none were noted. B. Following which on 11/19/15, resident □s wound areas were re-dressed per physician □s order by the treatment nurse. C. Nursing staff for Resident #18 were re-educated by the Director of Nursing (DON) as to the process when dressings have become dislodged, missing, or soiled. D. The two licensed personnel that faile to respond to the 2 CNAs report of missing dressings were suspended pending investigation and terminated fror employment without returning to work. 2) Actions taken for any residents	i J
		wel and bladder. The SUPPLIER REPRESENTATIVE'S SIGNATURI		potentially affected:	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

12/16/2015

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CO	MPLETED
		345380	B. WING			С
	ROVIDER OR SUPPLIER	345380	B. WING	STREET ADDRESS, CITY, STATE, ZIP (1/20/2015
NAME OF PI	ROVIDER OR SUPPLIER			1601 PURDUE DRIVE	CODE	
THE REHA	AB AND HC CTR AT VILL	AGE GR		FAYETTEVILLE, NC 28304		
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 309	Continued From page	a 1	F 30			
1 000	resident had 2 stage		FU	A. On/before 11/20/201	5 treatment	
	Teshuchi nau z slaye	o pressure dicers.		nurse audited all persons		
	A wound assessment	t of 10/08/15 noted that there		wounds/dressings to assu		
	was a stage 3 pressure ul identified on 10/08/15. Th	re ulcer to the right great toe		dressings were not missing	g, intact, and	
		5. The wound bed consisted		not soiled. No issues were		
		ssue and 50% slough with		B. All nursing will be re-in		
		nding skin. It was noted that		facility Staff Development		
	•	thickness wound in the Treatment ordered included		(SDC) on/before 12/18/15 the process for addressing	• •	
	•	nt). The wound measured		missing, or dislodged dres		
	1.5 centimeters by 1.	-		nursing personnel not in a		
	•	ilso noted that Resident #18		be contacted by the DON,		
	had multiple severe o	contractures.		designee, and given the in to the employee⊡s next so	formation prior	
	A physician's order of	f 10/09/15 noted to clean the		3) Actions taken to preve	ent further	
		sal head with normal saline,		recurrence:		
		ep to the periwound. It		A. All nursing staff will re		
		el size layer of santyl to the apply moistened collagen		on/before 12/18/15 with re process for addressing so		
		n dressing daily and as		dislodged dressings. Any		
	needed.	in areasing daily and do		personnel not in attendance	•	
				contacted by the DON, or		
	A wound assessment	t of 10/23/15 for Resident		designee, and given the in		
		wound was identified on		to the employee⊡s next so		
	-	ar area of the right heel. The		B. The facility treatment		
		isted of 70% granulation		appropriate designee, will		
		h. The wound measured		rounds on all residents wit		
	4.5 centimeters by 5.	ent included santyl for		dressings to insure dressir and not soiled 5X per wee	-	
		noted that Resident #18 had		and as needed. Followed		
		which challenged staff when		weeks, and as needed, Fo		
	positioning.	-		monthly X 2 months, and a	as needed. Any	
				non-compliance will be ad		
		f 10/23/15 noted to clean the		immediately by the treatme	ent nurse or	
		with normal saline and pat		appropriate designee.	aunioating	
		skin prep to the periwound te layer of santyl to the		C. The process for communesolved issues or conc	-	
	wound bed. It was no			emphasized in the facility		
	moistened collagen o			programming.		

Facility ID: 943524

				FO	ED: 04/20/2017 RM APPROVED NO. 0938-0391
DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DA	TE SURVEY MPLETED
	345380	B. WING			C 11/20/2015
VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ē	
			1601 PURDUE DRIVE		
			FAYETTEVILLE, NC 28304		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
a wound assessment pressure ulcer to the measured 4 centimeter 0.3 centimeters with 7 00% slough. It was n and the treatment of s a wound assessment that noted the pressure metatarsal measured centimeters by 0.3 centimeters by 0.4 centimeter	lered foam and wrap with ure with tape daily and as a of 10/30/15 noted the plantar area of the right heel ers by 5.5 centimeters by 70% granulation tissue and oted there were no changes santyl continued. a of 10/30/15 for Resident re ulcer to the right 1.5 centimeters by 1.4 entimeters with a wound bed unulation tissue and 20% a of 11/13/15 noted the stage of the right heel had bund bed of 30% slough, re and 20% eschar. ged to santyl with xerofoam non-bordered foam and e daily. a of 11/17/15 noted the area now an unstageable wound tissue, 30% slough and bund bed. It was noted that to deteriorate. served resting in bed on his on 11/18/15. There was a ted in the room. erved beginning at 11:15 AM atment nurse assisted by	F 3(4) Monitoring for outcomes of established plan and involvem facility QAA/QAPI committee: A. Outcomes of wound dress will be reviewed by the adminiter team during morning administ meeting weekly X 4 weeks, for monthly X 2 months. B. Outcomes of wound dress will be presented to the facility committee by the treatment nuappropriate designee monthly months, and as needed. C. Any non-compliance with plan will reviewed by the QAA committee for root cause and interventions implemented as and/or established plan revise Discussion, interventions, and to established plan will be inclimeeting minutes. D. Any adjustment to the estable plan, through revision and/or if for non-compliance will require re-inservicing of the applicable DON, Treatment Nurse, or applicable DON, Treatment Nurse, or applicable will require the monitoring to be applicable will require the monitor will require the monitor will be applied to the stable will require the monitor will be applied to the stable will require the monitor will require the monitor will be applied to the stable will require the monitor will require th	ent of sing audits strative rative llowed by sing audits QAA/QAPI urse, or X 3 established /QAPI needed d. /or revisions uded in the ablished nterventions e staff by the propriate sished plan egin again	
	FOR MEDICARE & DEFICIENCIES ORRECTION AND HC CTR AT VILL SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page cover with a non-bord olled gauze and sect action of gauze and sect oneeded. A wound assessment of sector to the measured 4 centimet 0.3 centimeters with 7 30% slough. It was no and the treatment of sector and the treatment of sector and the treatment of sector and the treatment of sector consisting of 80% grassion betatarsal measured consisting of 80% grassion betatar area of sector and cover with a wound assessment to the plantar area of beteriorated with a wo 50% granulation tissu Freatment was chang gauze and cover with vrap with rolled gauze A wound assessment o the right heel was no solver with a mo folk granulation tissu freatment was chang gauze and cover with vrap with rolled gauze A wound assessment o the right heel was no solver to the wo he wound continued Resident #18 was ob eff side at 11:00 AM slight odor of stool no Wound care was obson 11/18/15. The treat	ORRECTION IDENTIFICATION NUMBER: identification NUMBER: 345380 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 cover with a non-bordered foam and wrap with olled gauze and secure with tape daily and as needed. A wound assessment of 10/30/15 noted the Deressure ulcer to the plantar area of the right heel neasured 4 centimeters by 5.5 centimeters by 0.3 centimeters with 70% granulation tissue and 30% slough. It was noted there were no changes and the treatment of santyl continued. A wound assessment of 10/30/15 for Resident #18 noted the pressure ulcer to the right netatarsal measured 1.5 centimeters by 1.4 centimeters by 0.3 centimeters with a wound bed consisting of 80% granulation tissue and 20%	FOR MEDICARE & MEDICAID SERVICES DEFICIENCIES ORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIL A. BUILDIN 345380 B. WING	FOR MEDICARE & MEDICAID SERVICES DEFICIENCIES (X1) PROVIDERSUPPLIERCLIA ABUILDING A BUILDING IDENTIFICATION NUMBER: A BUILDING AND KC CR AT VILLAGE GR STREET ADDRESS, GITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PRECIDED BY FILL RECOLATORY OR LISC DENTIFYING INFORMATION) DPROVIDER'S PLAN OF COT (EACH OFCENCY MUST BE PRECIDED BY FILL RECOLATORY OR LISC DENTIFYING INFORMATION) PREFIX Continued From page 2 PREFIX PREFIX Continued From page 2 F 309 Continued From page 2 Contimute from the page 2 Wound assessment of 10/30/15 noted the researce ucler to the right neel meatarsal measured 1.5 centimeters by .3.3 centimeters by 5.5 centimeters by .3.3 centimeters with 70% granulation tissue and 20% isough. B. Outcomes of wound dress will be presented to the facility committee by the treatment nu appropriate designer monthy pauze and cover with non-bordered foam and wrap with rolled gauze daily. A wound assessment of 11/17/15 noted the stage 8 to the right heel was now an unstageable wound with 30% granulation tissue, a0% slough and 00% granulation tissue, a0% slough and 00% schar to	ENT OF HEALTH AND HUMAN SERVICES FO POR MEDICARE & MEDICAID SERVICES OMB I DEPROENCES OMB I DEPROENCES OMB I DEPROENCES OMB I OWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE IADD HC CTR AT VILLAGE GR STREET ADDRESS, CITY, STATE, ZIP CODE INDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INDEX OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INDEX OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INDEX OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INDEX OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INDEX OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INDEX OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INDEX OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE ConTINUED SUPPLIER STREET

Facility ID: 943524

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		D HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		PLETED
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE REH	AB AND HC CTR AT VILL	AGE GR			601 PURDUE DRIVE AYETTEVILLE, NC 28304		
(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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 309	gloved. NA #1 assiste Resident #18. It was contractures of both le leg was drawn up tigh across the left upper to resting against the inner treatment nurse remo- padded boots from his used scissors to remo- dressing. She cleaner of the great toe with m She applied a thick la the open wound and to piece of collagen. She foam dressing and tay observation, the wour was approximately the dark pink and yellow s wound bed. The treat large black area to the right heel with normal several times in an eff dry flaky skin from arco patted it dry and applit moistened piece of co covered it with a foam the entire foot with a foam the number side co skin was a fragile pint skin. There was no d	vashed their hands and ed the nurse to reposition noted that he had severe ower extremities. The right at to his waist positioned thigh with the right foot her upper thigh. The wed both of the green is feet. The treatment nurse ove the rolled gauze ed the right metatarsal head formal saline and patted dry. yer of santyl ointment onto then placed a moistened e covered the wound with a poed it in place. Upon not to the right metatarsal e size of a nickel with pink, scattered tissue in the tment nurse cleaned the e right plantar surface of the saline. She wiped it fort to remove some of the pound the wound. She then end santyl ointment with a ollagen over the wound and n pad. She then wrapped rolled gauze dressing. The approximately 4 inches in the heel and extended up of the heel. The surrounding k with dry and flaky pieces of rainage noted.	F	309			

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	MENT OF HEALTH AN S FOR MEDICARE & I				FORI	D: 04/20/2017 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	E SURVEY PLETED
		345380	B. WING			C / 20/2015
NAME OF P	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE	· · ·	
			1	601 PURDUE DRIVE		
	AB AND HC CTR AT VILL	AGE GR	F	AYETTEVILLE, NC 28304		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	was noted in the chain A bed bath was obser Resident #18 beginnin NA #2 and NA #3 was NA #2 prepared 2 bas bath. As they uncover noted that the green f on the right foot and t noted to the 2 wounds was a urine soaked w right foot. When NA # was also a moderate drainage noted on the had been. NA #2 was exception of his hand washed. When quest stated the third shift N her this morning wher dressings had been re due to being soiled wi stated NA #4 told her around his foot. NA # for Resident #18 befo AM but wasn't sure o reported Resident #18 towel that was around urine. She stated she placed a clean towel a also reported that she (Nurse #1) about the around 7:20 AM but s time. NA #2 stated N towel around the right nurse could get to it.	M, the green foam boot in his room. ved being provided to ng at 11:00 AM on 11/19/15. shed their hands and gloved. sins of water to provide the red Resident #18, it was oam boot was not in place here were no dressings s on his right foot. There hite towel folded around the #2 removed the towel there amount of bloody brownish towel where the right heel shed his upper body with the s. His right foot was not ioned at 11:20 AM, NA #2 IA (NA #4) had reported to n she came on duty that the emoved around 3:00 AM th stool and urine. NA #2 she had wrapped a towel f2 stated she provided care re breakfast at about 7:10 f the exact time. She b had been wet and the I his right foot was wet with e changed his bed pads and around the right foot. NA #2 informed the hall nurse dressings not being in place he wasn'tt sure of the exact urse #1 told her to place the foot until the treatment NA #2 stated she had not ent #18's room to change	F 309			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/20/2017 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345380	B. WING		_	(11/:) 20/2015
NAME OF P	ROVIDER OR SUPPLIER		· ·	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				1601 PURDUE DRIVE			
	AB AND HC CTR AT VILL	AGE GR		FAYETTEVILLE, NC 283	304		
(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	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page There was a small dre heel of Resident #18's PM. The treatment nurse wat at 1:10 PM. She state anything to her about being removed. She hall just a few minutes her that his dressings nurse stated the phys dressings were daily b She stated if the dress off the hall nurse had replace the dressing. should not be left off of of time. The treatmer was the responsibility replace the dressing i and removed on third stated "no wonder his The treatment nurse s a dressing to the heel great toe metatarsal w would provide wound right foot and replace Nurse #1 was intervie PM. Nurse #1 stated dressings were not in right foot earlier today she was busy and told around the foot until s room. Nurse #1 stated she had given Reside	e 5 essing in place to the right a foot on 11/19/15 at 1:30 was interviewed on 11/19/15 ed Nurse #1 never reported Resident #18's dressings stated she saw NA #2 in the s ago and she reported to were off. The treatment ician's orders noted that the but were also as needed. sing became soiled or came access to supplies to She stated a dressing of a wound for a long period at nurse commented that it of the third shift nurse to f the dressing was soiled shift. The treatment nurse s wound is getting worse." stated Nurse #1 had placed wound but not to the right vound. She stated she care to both areas on his the green foam boot. weed on 11/19/15 at 1:30 NA #2 had reported the place to Resident #18's a round breakfast time but d her to put something the could get down to his ed NA #2 told her later that ant #18 a bath. She reported	F 309] 			
	after that. When ques the issue to the treatment	room and placed a dressing stioned if she had reported nent nurse she responded what her schedule was or					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/20/2017 / APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>				(X3) DATE COMP	SURVEY LETED
		345380	B. WING					C 20/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE	, ZIP CODE		
				1	601 PURDUE DRIVE			
	AB AND HC CTR AT VILL	AGE GR		F	AYETTEVILLE, NC 28304			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page when she would get to if it took too long for the replace the dressing set NA #4 was interviewed at 2:08 PM. She state night and had provide #18 around 3:00 AM. bowel movement and with stool. She stated and reported it to Nur- wrapped the right food reported she provided end of the shift and the She also stated there drainage noted on the that she reported it ag end of the shift. NA # informed NA #2 of the duty this morning. Nurse #2 was interviee 11/19/15 at 2:40 PM. that Resident #18 had She stated if the dress only one who would in Nurse #2 stated the N needed to be replaced stated Resident #18 v was difficult to keep the into contact with urine reported that the dress earlier in the week an	 a 6 b Resident #18. She stated he treatment nurse to she would do it. d via telephone on 11/19/15 ed she worked third shift last d personal care to Resident She stated he had a large his dressings were covered d she removed the dressings se #2. She stated she e towel was wet with urine. Was bloody brownish to towel. NA #4 commented yain to Nurse #2 toward the 4 reported that she e issue when she came on wed via telephone on She stated she was aware d a wound on one of his feet. Sing came off she was the eed to address the issue. IA would let her know if it d or changed. Nurse #2 was very contracted and it he right foot from coming e and stool. Nurse #2 sing had been off one night d the bed pad was 		309	DEF			
	night. She stated she his buttocks and his h coming into contact w commented that she h							

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	S FOR MEDICARE &					<u>IO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY
		345380	B. WING		1	C 1/20/2015
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
	AB AND HC CTR AT VILI	ACE CB		1601 PURDUE DRIVE		
				FAYETTEVILLE, NC 28304		
(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) COMPLETIO DATE
F 309	Continued From page	o 7	F 309			
		rse #2 commented that the	1 000			
		el would never heal if urine				
	•	to contact with it. She				
	denied that NA #4 ha	d reported the issue				
		igs not being in place last				
		' t remember being told				
	about it.					
	The Director of Nurse	es (DON) was interviewed on				
		She stated the hall nurses				
	were expected to rep	lace the dressings any time				
		ue to being soiled or if the				
	•	any reason if the treatment				
		ble. She also commented the				
	-	e been washed to remove the also reported that on				
	•	lift nurse was responsible for				
	wound treatments for	-				
	resident rooms and the	he night shift nurse was				
		dd numbered rooms. The				
		ovember 2015 treatment				
		s for Resident #18 during				
	-	review of the November nistration record for Resident				
		t there were blanks on				
		1/08/15, 11/09/15, 11/14/15,				
	0	oot metatarsal head and the				
		to the plantar area of the				
	-	reported she did not know				
		not being provided on I also reported the third shift				
		buld have replaced the				
		reported. She commented				
	0	t Resident #18 to go from				
		M until after 11:30 AM today				
	-	place to the right foot.				
F 312	483.25(a)(3) ADL CA		F 312	2		12/18/15
SS=D	DEPENDENT RESID		1			1

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/20/2017 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		ONSTRUCTION		LETED
		345380	B. WING				C 20/2015
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
THE REH	AB AND HC CTR AT VILL	AGE GR		1601 PURDUE DRIVE FAYETTEVILLE, NC 28304			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From page	2 8	F3	312			
	daily living receives th	ble to carry out activities of ne necessary services to on, grooming, and personal					
	by: Based on observatio interviews, the facility bed bath for 1 of 1 re- whose bath was bein included: The facility's undated bath noted to wash ai hands, axilla, buttock undated policy for pro- wash face, chest, abo hands, back, buttocks Resident #18 was re- 05/28/14. Cumulative peripheral vascular di- right hip and knee, co and pressure ulcers. Resident #18's care p an onset date of 05/1 breakdown related to incontinence. The most recent Qua (MDS) assessment o Resident #18 had sev making skills and req	admitted to the facility on e diagnoses included isease, contractures of the ontractures of the left hand blan identified a problem with 4/15 as being at risk for skin impaired bed mobility and rterly Minimum Data Set			F 312: 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 1) Actions taken for Resident #18 include the following: A. On 11/19/2015 the resident was g a complete bed bath per facility protoc On 11/19/2015 the resident is left har which held the adaptive equipment, w thoroughly washed and clean adaptive equipment repositioned into left hand following cleaning. 2) Actions taken for all residents due the potential for being affected: A. All nursing will be re-inserviced b facility Staff Development Coordinator (SDC) on/before 12/18/15 regarding the process for performing a resident bed bath, to include the removal of any adaptive equipment as allowed to pro- opportunity for cleaning area and equipment. Any nursing personnel r attendance will be contacted by the D or appropriate designee, and given the information prior to the employee is n scheduled shift. B. On/before 11/23/2015, the DON, appropriate designee reviewed reside care guide to identify residents receivit	col nd, as e to y the he vide not in ON, e ext or nts□	

Facility ID: 943524

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · /	TE SURVEY MPLETED
			A. BUILDING	<u> </u>		
		245280	B. WING			С
		345380	B. WING			1/20/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE REH	AB AND HC CTR AT VILI	_AGE GR		1601 PURDUE DRIVE		
				FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE . DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 312	Continued From page	e 9	F 31	2		
		ent of both bowel and	1.01	bed baths and/or those reside	nts with	
		it had 2 stage 3 pressure		adaptive equipment and the ty		
	ulcers.			adaptive equipment. Care gui		
				updated as needed and inform		
	A bed bath was obse	rved being provided to		relayed to CNA staff by the DC		
		ing at 11:00 AM on 11/19/15.		appropriate designee.	, -	
		shed their hands and gloved.		3) Actions taken to prevent f	urther	
		sins of water to provide the		recurrence:		
		ered Resident #18, it was		A. All nursing will be re-inser	viced by the	
	-	nd was contracted with a		facility Staff Development Coo		
	red/orange carrot-sha	aped protector in place within		(SDC) on/before 12/18/15 reg	arding the	
	the hand. NA #2 was	shed his face, chest and		process for performing a resid	ent bed	
	arms. She did not re	move the carrot shaped		bath, to include the removal of	fany	
	protector from his left	t hand nor did she wash his		adaptive equipment as allowe	d to provide	
	left hand. Resident #	418 had a severely		opportunity for cleaning area a	and	
	contracted right leg w	hich was drawn up close to		equipment. Any nursing pers		
	-	on the upper left thigh. The		attendance will be contacted b	•	
		up against the inner upper		or appropriate designee, and		
	left thigh within very of			information prior to the employ	/ee⊡s next	
		e staining was noted on the		scheduled shift.		
	•	18 also had a moderate		B. Random observation of ca		
		stool on his skin. It was		include bed bath skills checklis		
		a urine soaked white towel		conducted a minimum of 3X w		
		ht foot. When the towel was		weeks (to include 2nd shift and	a weekends	
		moderate amount of bloody		as applicable).	un al a una	
		oted on the towel where the		C. This will be followed by ra		
		ositioned. Resident #18 had		weekly audits X 2 weeks, follo		
		s right foot and no dressings		monthly X 2 months, followed	by quarterly	
	-	2 continued with bathing . His legs were contracted		X 2 quarters, and as needed. D. The observation of care, t	o include	
		t able to spread his legs to		bed bath skills checklist, will b		
		washed his perineal area and		in the facility clinical unlicense		
		could. She removed the soft		orientation.		
		rectum, inner buttocks and		E. Any non-compliance in pr	oviding hed	
		wn was placed. The soiled		baths, to include attention to re	-	
		d and a clean one placed		with adaptive equipment, will b		
		#18. Resident #18's back,		to the DON, or appropriate de		
		ot washed. The aides		corrective action will be taken	-	
	1.530 and 1001 word no		1		40 00011 40	

Facility ID: 943524

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	. ,	TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		СО	MPLETED
		345380	B. WING			C
	ROVIDER OR SUPPLIER	040000		STREET ADDRESS, CITY, STATE, 2		1/20/2015
				1601 PURDUE DRIVE		
THE REHA	AB AND HC CTR AT VILL	AGE GR		FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETIO DATE
F 312	Continued From page	- 10	F 312	2		
	linens.		1 012	F. The process for co	mmunicating	
				unresolved issues or co	•	
	After mouth care was	completed at approximately		included in the above re		
		were questioned about		and emphasized in the	facility orientation	
		 Neither aide was able to 		programming.		
	report the last time th			Monitoring for outc		
	-	y had been on different		established plan and in		
		stated she had washed his she worked with him which		facility QAA/QAPI comr A. Outcomes of obser		
		id. NA #2 was not sure when		audits, to include bed b		
		left hand. NA #3 removed		will be reviewed by the		
		otector from his left hand and		team during morning ac		
		she opened the hand, a		meeting weekly X 4 we		
	very foul odor was de	etected. NA #3 washed his		monthly X 2 months.		
	left hand and dry skir	n was observed flaking off		B. Outcomes of obser	vation of care	
		d linens. NA #2 stated she		audits, to include bed b		
		ctive device to the laundry		will be presented to the	•	
		e placed in the left hand ed protector was being		committee by the treatment of appropriate designee m		
		as questioned as to washing		months, Followed by qu		
		ed his left foot but she never		quarters, and as neede	-	
		which had been covered		C. Any non-compliance		
	-	owel. She stated when she		plan will reviewed by th		
	came on duty this mo	orning NA #4 had reported to		committee for root caus	e and	
		oved the dressings from his		interventions implement		
) AM this morning when she		and/or established plan		
	•	care. She stated NA #4 told		Discussion, interventior		
		had become soiled with		to established plan will	be included in the	
		ne had placed a clean towel stated when she provided		D. Any adjustment to	the established	
		roximately 7:10 AM the pad		plan, through revision a		
		oth soaked with urine and		for non-compliance will		
		an towel around the right		re-inservicing of the app		
	-	orted that the facility had a		DON, or appropriate de	-	
		ne was constantly having to		E. Any revision to the		
		ide care as he was not		will require the monitori		
	-	#2 added that she had not		at Step 4A and continue	e as outlined.	
	been back in to chan	na Rasidant #18 sinca har	1			1

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If continuation sheet Page 11 of 76

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 04/20/201 MAPPROVE D. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		STRUCTION	(X3) DATE SURVEY COMPLETED	
		345380	B. WING _				C / 20/2015
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET	ADDRESS, CITY, STATE, ZIP CODE		
	AB AND HC CTR AT VILL	AGE GR		1601 PI	JRDUE DRIVE		
				FAYET	TEVILLE, NC 28304		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 312	Continued From page	e 11	F	312			
F 315 SS=G	11/19/15 at 5:00 PM. were to be washed di included hands and for were provided based resident was not sche complete bed bath we 483.25(d) NO CATHE RESTORE BLADDER Based on the residen assessment, the facil resident who enters to indwelling catheter is resident's clinical com catheterization was no who is incontinent of treatment and service	as to be given. ETER, PREVENT UTI, R It's comprehensive ity must ensure that a	F	315			12/18/15
	by: Based on physician record review the fac a urinalysis for ten da antibiotic treatment a for fifteen days after r describing painful sig sampled residents (R experienced a urinary Findings included: Resident #287 was a 08/18/08, readmitted			PR 1) the 2) poi A. by res do: No B.	315: 483.25(d) NO CATHETER, EVENT UTI, RESTORE BLADDEF Resident #287 was discharged fr facility on 5/8/15 and has not retur Actions taken for any residents tentially affected: A review was conducted on 11/2 the Administrative Nursing Team o sidents receiving antibiotics to insur ses had been inadvertently omitted ne were discovered. On 11/24/15, Administrator called ending physician to discuss results	om med. 20/15 n all e no	

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION		<u>D. 0938-03</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G		PLETED
						С
		345380	B. WING		11	/20/2015
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP	CODE	
				1601 PURDUE DRIVE		
	AB AND HC CTR AT VIL	LAGE GR		FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 315	Continued From pag	e 12	F 31	15		
1 010					o aivo moro	
		ed diagnoses included chronic anxiety disorder,		survey. Also asked him to timely responses to our n	•	
	cerebrovascular acci	-		regarding his patients and		
		d speech, bradycardia, and		detailed notes in our syste		
	hypertension.			judgement calls that might		
				later.		
	On 06/24/14 the resi	dent's care plan identified, "I		3) Actions taken to prev	ent further	
	have occasional epis	odes of incontinence" as a		recurrence:		
	problem. The reside	nt's care plan was last		A. All licensed nursing s		
	reviewed on 03/23/1			re-inserviced on/before 12		
		his problem. Interventions to		method of notifying physic		
	-	d, "Observe me for acute		relay any delay of respon		
	behavioral changes t	that may indicate UTI."		to the DON, or appropriat		
	The resident's 03/16	/15 quarterly minimum data		either verbally or on the 2 report.	4 nour nursing	
	set (MDS) document			C. All licensed nursing s	staff will be	
	severely impaired, th			re-inserviced on medicati		
	delirium, the resident	-		on/before 12/18/15, with s		
		it was feeling tired, the		to following physician ord		
		ncing poor appetite, the		doses, and notification of		
		trouble concentrating, there		administrative and physic		
	was no evidence of p	osychosis, the resident		omitted.		
	exhibited no behavio	rs, the resident did not reject		D. Any licensed nursing		
		nt was not wandering. The		attendance will be contac		
	-	ensive assist with her		or appropriate designee,	•	
		ng except she was totally		information prior to the er	nployee⊡s next	
		or bathing. The resident was		scheduled shift.		
		it of bowel and bladder, and s since her last MDS with one		E. The process for com unresolved issues or con	-	
	resulting in non-majo			included in the above liste		
				emphasized in the facility		
	A 04/09/15 (Sundav)	physician progress note (the		programming.		
	-	edical record before the		F. The Administrative N	ursing Team will	
		lized on 05/08/15) did not		continue to review each 2	•	
	-	changes in Resident #287's		report at a minimum of 5>	÷	
	health status. The n	ote documented a routine		on-going for appropriate a	and timely	
		t being alert, but not oriented		interventions. The DON, o	-	
		teoarthritis was noted in the		address any non-complia		
	hands and feet. the r	esident was unable to follow		outcomes with the applica	able staff	

Facility ID: 943524

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	. ,	IPLETED
						С
		345380	B. WING		11	/20/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	PCODE	
тис реи	AB AND HC CTR AT VILI			1601 PURDUE DRIVE		
				FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 315	Continued From page	e 13	F 31	15		
		s evidence of advancing		personnel, physician, and	d family as	
		a with recent TIA (transient		needed.	a lanniy do	
		resident was continuing a		G. The DON, or design	ee, will audit 25%	
	DNR (do not resuscit	tate) status, and there was to		of all residents on antibio		
	be a continuation of o	comfort measures.		following timeline:		
				a. Weekly X 4 weeks		
		sident #287's primary		b. Monthly X 2 months		
		e #1 documented, "Rsdt		c. Quarterly X 2 quarte	rs	
		on 11 - 7 shift last night. mbative, hallucinating. Urine		H. 2 Medication Pass C	beenvations will	
		ol used) gray tint. Strong odor		be conducted weekly x 2		
		s of) pain when urinating.		by monthly on-going. Th		
		(at) current & request she		contacted by a member of		
	gets a UA/C & S ASA	AP (urinalysis/culture and		Administrative Nursing Te	eam and/or	
	sensitivity as soon as			pharmacy personnel duri	ng their monthly	
		nad UTI. Please advise!"		visit.		
		the resident's 04/21/15 10:		I. Any non-compliance		
		re blood pressure of 144/86,		be addressed by the DO as discovered.	N, or designee,	
		s 18, temperature 98.1, and i% on room air. Also		4) Monitoring for outco	mes of	
		acility's copy was, "Temp		established plan and invo		
	(temperature) 99.9 u			facility QAA/QAPI commi		
	handwritten entry wa			A. Outcomes of antibio		
				compliance audits and th	-	
		ative behavior during care		Pass Observations will b		
		y) striking out at and pulling		administrative team durin		
	-	sk of injury to self/others and		administrative meeting w		
	undue stress r/t (in re			followed by monthly X 2		
		y identified as a problem in an. Interventions to this		B. Outcomes of Medica Observation will be prese		
		ionitor and document my		facility QAA/QAPI comm		
	behavior Q (every) sl			nurse, or appropriate des		
		a, administer medications as		3 months, quarterly X 2 c	• •	
		, monitor effectiveness of		needed.		
	resident drug regime			C. Medication Pass Ob	servation	
				outcomes will continue to		
	-	nary physician faxed a reply		the Medication Managem		
		If still symptomatic (i.e.		Sub-Committee section of		
	having dysuria) obta	in in and out cath for U/A, C		Committee quarterly mee	tinas on-aoina	

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		MEDICAID SERVICES	(X2) MELTE		CONSTRUCTION		IO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	, ,			1 Y Z	MPLETED	
							С	
		345380	B. WING			1	1/20/2015	
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
THE REH	AB AND HC CTR AT VILL	AGE GR			01 PURDUE DRIVE YETTEVILLE, NC 28304			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 315	Continued From page	e 14	F 31	15				
	& S only if pyuria."				D. Any non-compliance with establis	shed		
					plan will reviewed by the QAA/QAPI			
		locumented Resident #287's 9 degrees Fahrenheit (with			committee for root cause and interventions implemented as needed			
		s in April 2015 on 04/06/15,			and/or established plan revised.			
(r (() () () () () () () () (and 04/27/15 being within			Discussion, interventions, and/or revis			
	normal range).				to established plan will be included in	the		
	Lab results documen	ted urine was collected on			meeting minutes. E. Any adjustment to the established	ч		
		& S available on 05/04/15			plan, through revision and/or interven			
	which showed greate				for non-compliance will require			
		(CFU) of Escherichia coli			re-inservicing of the applicable staff b	y the		
	bacteria.				DON, or appropriate designee. F. Any revision to the established pl	an		
	A 05/05/15 4:44 PM	progress note documented,			will require the monitoring to begin ag			
		of the day and consumed 0%			at Step 4A and continue as outlined.			
		0 cc (cubic centimeters) of						
		e day. Family also stated I PRN (as needed) pain						
	medication administe							
	effect"							
	A OF/OF/15 physician	order started Decident #207						
		order started Resident #287 otic 250 milligrams (mg) by						
	mouth four times dail							
	A 05/06/15 fax to Res	sident #287's primary 1 documented, "Rsdt family						
		BMP (complete blood count						
	and basic metabolic	panel) on rsdt. Rsdt						
	currently not consum	ing food or liquids."						
	A 05/06/15 physician CBC/BMP today."	order documented, "Check						
		progress note documented, n bed throughout 3 - 11 shift.						
		n bed throughout 3 - 11 shift. Id unlabored. Skin warm						
		tal care provided by staff,						

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/20/2017 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345380	B. WING			_		C 20/2015
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
	AB AND HC CTR AT VILL	ACE CB		1	1601 PURDUE DRIVE			
	AND HE CIK AT VILL	AGE GR		F	AYETTEVILLE, NC 28	304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315		nember consuming 100% of	F	315				
	dinner intake. ABT (a no adverse reactions voiced, no distress no	-						
	(MAR) documented sl Tetracycline at 2:00 A	ication administration record he received her first dose of M on 05/06/15, but did not 2:00 PM, and 8:00 PM c on 05/06/15.						
	"Resident in bed resti members at bedside r care, fed by family me	progress note documented, ing entire shift with family most of shift. Received total embers, appetite good an 75% of dinner intake."						
	The resident's MAR d four doses on antibiot	locumented she received all tic on 05/07/14.						
	"Resdt in bed all morr family @ bedside. Die	unts of liquidsABT in						
	the resident's blood p was 92, respirations v	progress note documented ressure was 126/82, pulse were 20, temperature was uration was 95% on room						
	#287 was being sent	order documented Resident out to the emergency room ation per family request due and abdominal pain.						
		locumented she received tic on 05/08/15 before she						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345380	B. WING				C / 20/2015
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
THE REHA	AB AND HC CTR AT VILL	AGE GR			1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(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 F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 315	home for evaluation of patient is lethargic. SI spontaneously to vert communicate, but no be obtainedAppare complaints of abdomi with a urinary tract inf She was started on the continued to get wors talk and answer ques the (family memb patient has not been a Also, the patient's inta significantly, which has also states the patien foul and is very dark i apparently used to us but for the last few we status has also declin of fever, chills, nause pain, shortness of bre dizziness, or rash" Results from the CBC 05/11/15 with the whit 22.8 (the normal rang A hospital final summ #287 passed away in Death diagnoses wer sepsis and complicate At 2:25 PM on 11/18/	istory and physical brought in from nursing of change in mentation. The ne opens her eyes bal commands. She tries to meaningful information can ently the patient has nal pain and was diagnosed fection in the nursing home. etracycline, but the patient e. The patient can usually tions, but for the last 2 days, ber designation) states the able to communicate at all. ake has decreased as complicated things. She t's urine has smelled very n color. The patient e a wheelchair to ambulate, eeks the patient's functional led tremendously. No report a, vomiting, diarrhea, chest eath, lightheadedness,	F	315			
		xperiencing when she faxed					

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		ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 04/20/2017 ORM APPROVED NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,			(X3) D	DATE SURVEY OMPLETED
		345380	B. WING				C 11/20/2015
NAME OF PE	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				160	1 PURDUE DRIVE		
THE REHA	AB AND HC CTR AT VILL	AGE GR		FA	YETTEVILLE, NC 28304		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 315	resident's family infor recognized these as a experienced by the re- in the past. Accordin continued to experien symptoms, and she p calls to the physician' (there was no docum in the resident's medi- commented she was physician during thes nurses told her that th her concerns about F be back in touch. Nu physician response w reporting it was not u week or longer for fee Resident #287's phys At 2:50 PM on 11/18/ stated for a couple of #287 went out to hos resident had some ha reported she wanted more frequently tried up unassisted. Durin NA commented the re go to the bathroom, a urinate, complaining of According to the NA, resident having brown a couple of weeks, bu have been unusual for reported she thought	 21/15. She also reported the med her that they the signs and symptoms esident when she had UTIs g to Nurse #1, the resident nce all these signs and blaced three follow-up phone is office on multiple days entation of these phone calls ical record). She not able to talk to the e follow-up calls, but his ne physician was aware of Resident #287 and he would rse #1 stated this lag in vas not an isolated incident, ncommon to have to wait a edback and orders from sician. 15 nursing assistant (NA) #5 weeks before Resident pital on 05/08/15 the allucinations, moaned, to get out of the facility, and to do unsafe things like get g this same time period the esident would say she had to and then be unable to of feeling pressure. 	F	315			
		ome complaints of day before the 05/08/15 commented she was told by					

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/20/201 FORM APPROVE OMB NO. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345380	B. WING _		C 11/20/2015
NAME OF P	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIF	
	AB AND HC CTR AT VILL	AGE GR		1601 PURDUE DRIVE	
				FAYETTEVILLE, NC 28304	
(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 COMPLETION O THE APPROPRIATE DATE
F 315	history of UTIs, and h that she was going th At 4:30 PM on 11/18/ couple of weeks befo hospitalization Reside confused, was less a and was falling more she was unsure abour resident's urination du However, she commended having concerns sayi was exhibiting signs a they were getting more resident's doctor was commented delays of uncommon after faxing in resident condition of resident health. She could do about the de office and talk to nurse already passed the in physician. At 3:06 PM on 11/19/ the resident was last about all she could re couple of weeks in the seemed more weak, resident was able to g reported Resident #2 UTIs, but had enough	the resident had a past her family was concerned rough the same thing again. 15 Nurse #5 stated for a re her 05/08/15 ent #287 seemed more ble to do things for herself, frequently. She reported it any changes in the uring this time period. ented she recalled the family ng they thought the resident and symptoms of a UTI, and re aggravated because the not responding. Nurse #5 f a week or longer were not ng physicians about changes or about concerns with explained that about all you elay was call the physician sees who would say they had formation on to the 15 NA #6 stated because in the facility so long ago emember was in her last e facility Resident #287 was more confused, and the go to the bathroom less. She 87 did not have frequent n in the past that the family when the resident had a UTI	F 3		
	(DON) stated there w	15 the director of nursing rere two ways to as in resident condition to the			

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				E CONSTRUCTION		IO. 0938-039	
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED	
			A. BUILDING			С	
		345380	B. WING				
	ROVIDER OR SUPPLIER	0.0000		GTREET ADDRESS, CITY, STATE, ZIP CODE	1 1	1/20/2015	
				601 PURDUE DRIVE			
THE REH	AB AND HC CTR AT VILI	_AGE GR		AYETTEVILLE, NC 28304			
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	PECTION	(YE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE	
F 315	Continued From page	e 19	F 315				
		he explained if the change					
		es could page physicians or					
	-	and if the change was not					
	urgent and a reply wi						
	acceptable then a co	mmunication form could be					
		e physician communication					
		staff usually called Resident					
		cian since he only had 2 or 3					
		ing. She commented he was					
	-	ich more than once a month					
	when he attended qu	to the DON, there was a					
		station where communication					
		faxed to physicians were					
		expected the nursing staff					
		e next day after the initial fax					
	to make sure a respo	onse had been obtained. If					
	there was no respons	se, she reported the nurse					
		the physician office. If the					
		get a response from the					
		none call, then the nurse was					
		matter to the unit or clinical					
	coordinator who wou						
		ning a response. The DON two weeks to get antibiotic					
	orders for someone						
	symptoms of a UTI w						
		nount of time the resident					
		completed antibiotic therapy					
	and been free of pair						
	At 8:42 AM on 11/20/	15, during a telephone					
		sident #287's primary					
		when residents experienced					
		the best way the nursing					
		was on his cellular phone.					
		g was acceptable also if the					
	problem was not urge	ent. The physician reported					
		sations with the former DON					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345380	B. WING				C 20/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE REH	AB AND HC CTR AT VILL	AGE GR			601 PURDUE DRIVE AYETTEVILLE, NC 28304		
(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 315 F 371 SS=E	before 05/01/15, and #287 was exhibiting of symptoms of a UTI ur elevated temperature there was no docume conversations in the r medical record). He s symptoms of a UTI in temperature, pelvic/al painful urination. Acc also stopped by to se visiting two other resid 05/03/15 (Sunday), and at baseline and in no there was not a physi resident's paper or ele 05/03/15). 483.35(i) FOOD PRO STORE/PREPARE/SI The facility must - (1) Procure food from considered satisfactor authorities; and	they did not think Resident lefinitive signs and ntil the resident had an on 05/02/15. (However, intation of such esident's paper or electronic stated definitive signs and cluded elevated bdominal/flank pain, and ording to the physician, he e Resident #287 while dents in the facility on nd Resident #287 seemed acute distress. (However, cian progress note in the ectronic medical record for CURE, ERVE - SANITARY sources approved or ry by Federal, State or local stribute and serve food		315			12/18/15
	by: Based on observation facility failed to sanitiz machine final rinse te 180 degrees Fahrenh	is not met as evidenced n and staff interview the kitchenware when dish mperatures did not reach eit, failed to maintain the alad made with mayonnaise			F 371: 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE SANITARY 1) Initial actions taken upon discovery concerns: A. Concerns		

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3		IPLETED
						С
		345380	B. WING	·····	1	1/20/2015
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 2		
				1601 PURDUE DRIVE		
	AB AND HC CTR AT VILI	LAGE GR		FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 371	Continued From page	e 21	F 37	1		
	at or below 41 degree			(1) The rinse cycle on	the dishwasher	
	operation of the trayli	•		did not reach the requir		
		tacking it on top of one		temperature of 180 deg		
	another in storage, fa			Maintaining accurate te		
		ood preparation surfaces		dishwasher.	-	
	and meal carts, failed	to clean kitchen equipment		(2) Cold foods (tuna sa	alad) was not	
	and filters, and failed	to label and date opened		maintained at 41 degree		
	food items. Finding i	ncluded:		(3) Kitchenware was n	ot left to air dry	
				before stacking		
		and 9:52 AM on 11/18/15 15		(4) Sanitizing solutions	-	
	racks of kitchenware	-		dietary staff to sanitize	food preparation	
	-	e. The wash and final rinse		surfaces/meal carts		
	gauges were not mor			(5) Kitchen equipment		
		the dish machine, and these		not cleaned on regular		
	employees were uns			(6) Open food items no	ot labeled or dated	
	chemical sanitization	chenware via heat or		when opened. B. Actions taken:		
		between 142 and 148		(1) On 11/18/2015 app	licable disbes were	
	degrees Fahrenheit.	between 142 and 146		re-rinsed until required		
	degrees Famermen.			cycle was obtained.	temp	
	At 9.55 AM on 11/18/	15 the facility's maintenance		(2) A new thermostat f	or the dishwasher	
		d the dish machine sanitized		was installed on 12/7/1		
		nal rinse temperatures		products were used unt		
		0 degrees Fahrenheit.		arrived and was installe		
				(3) On 11/18/2015 any		
	During a follow-up inf	terview with the MM at 10:56		was re-washed/rinsed/a		
		stated in response to a work		(4) On 11/18/2015 ide		
	order the thermostat	-		was discarded.		
	replaced in the dish r	nachine booster system		(5) On 11/18/2015, all	identified kitchen	
	about a week and a h	nalf ago. He reported on		surfaces were sanitized	l with appropriate	
		still problems with the dish		solution		
	-	es so a contracted service		(6) On/before 11/19/20		
		ed the thermostat in the		kitchen equipment and	filters were	
	-	MM commented he did not		cleaned.		
		n machine temperatures, but		(7) On/before 11/18/20		
		orders that concerned		items that were not labe		
	problems with the dis	sn machine.		opening were discarded		
		45 the kitcher manager		2) Actions taken for a		
	At 4:22 PM on 11/18/	15 the kitchen manager		the potential for being a	iffected:	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE SUR	38-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETE	
			A. BUILDING		с	
		345380	B. WING		11/20/2	015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/20/2	015
				1601 PURDUE DRIVE		
THE REH	AB AND HC CTR AT VILI	LAGE GR		FAYETTEVILLE, NC 28304		
			I			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CO	(X5) MPLETIO DATE
F 371	Continued From page	e 22	F 37	1		
	(KM) stated he exped			A. On/before 11/27/2015, appli	cable	
		achine to monitor the wash		dietary staff were re-inserviced b		
		es. He reported if the final		manager to the regulatory and s		
	rinse gauge did not re			requirements for above areas of		
	Fahrenheit as racks	of kitchenware were run		1) A(1)-(6), and		
	through, he expected	the racks to be rerun until		B. The process for communica	ting	
		re was reached or exceeded.		unresolved issues or concerns w		
		ould not be reached the KM		included in the above referenced		
		ary staff was to notify the MM		and emphasized in the facility or	ientation	
	or a member of the d	lietary management team.		programming.		
				C. Any dietary staff not in atten		
		9/15 a dietary employee,		in-service, were re-inserviced pri scheduled shift.	or to next	
		s sometimes included dish stated the dietary staff was		3) Actions taken to prevent fur	ther	
	-	ucted that the employee		recurrence:		
		itchenware from the dish		A. Dietary Manager has made	changes	
		sed to monitor the final rinse		in the way cold foods are prepar	-	
		did not register at least 180		Beginning on/before 11/20/2015		
		the employee reported the		foods will be prepared the day be		
	reset button was to b	e activated and the		kept in the cooler overnight and		
	kitchenware was to b	e run back through.		maintained in an ice bath on the	tray line	
	According to the emp	ployee, if a temperature of at		until served.		
	-	as not reachable then the		B. Dietary Manager re-inservic	-	
	MM was to be notifie	d immediately.		staff to procedure for maintaining		
				temperature logs to include, but		
		1/18/15 the cook took the		limited to, refrigerated equipmen		
		efore the trayline began ures on hot foods were		food/beverage temperatures, and dishwasher temperatures.	u	
		peratures were taken on cold		C. On/before 12/9/15 Dietary N	lanager	
	food items.			re-assigned cleaning schedules	-	
				following, dietary aides, cooks, s		
	At 11:50 AM on 11/18	8/15 after two tuna fish		and revised the cleaning of the	- /	
	sandwiches were pla	iced on resident trays, a		dishwasher. All schedules have		
	-	ter was used to check the		accompanying daily signature log	gs	
	tuna fish filling. The	sandwiches were being		included. Applicable dietary staf		
		vhich was placed on top of		informed of cleaning schedules a		
		d with ice. When placed in		expectations by the Dietary Man	ager	
		meter registered 56 degrees		on/before 12/9/15.		
	Fahrenheit. At this ti	me the dietary employee		D. On/before 12/9/15, Dietary I	Manager	

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	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION		D. 0938-039 SURVEY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	. ,			COMPLETED	
		345380	B. WING				20/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	AB AND HC CTR AT VILL	AGE GR		1	601 PURDUE DRIVE		
				F	AYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 371	Continued From page	e 23	F	371			
		bled the tuna salad reported		071	has established with applicable dieta	N	
	it contained tuna fish				staff that all delivered foods are	3	
		boiled egg. She stated she			labeled/dated when received and dat	ed	
	finished preparing the	e salad at about 10:00 AM tuna fish sandwiches had			upon opening. The kitchen manager checking all stored foods daily for	is	
	been in the reach-in r				dating/labeling and keeping a log she the daily checks.	et of	
	At 11:55 AM on 11/18	3/15 a large bowl of left			E. Dietary manager, or appropriate		
		lad (from which the filling for			designee, will perform audits of		
		been obtained) was removed			temperature logs for equipment and		
		igerator. The calibrated			food/beverages; appropriate air dryin		
	thermometer used to	ed 56 degrees Fahrenheit.			kitchenware; label/dating foods; sanit food preparation areas as follows:	izing	
		en manager (KM) stated he			(1) Daily X 5 times/week X 2 weeks,		
		to be assembled on the			followed by		
	-	to be served so they would			(2) Weekly times X 6 weeks, followe	ed by	
	be as fresh as possib	ble.			(3) Monthly X 4 months, followed by		
					(4) Quarterly X 2 quarters, and		
		15 the KM stated he was			(5) As needed		
	rethinking his stance	s made with mayonnaise in			F. Any non-compliance will be addressed by the Dietary Manager,		
		ney would be at or below 41			designee, as soon as practical.		
		during operation of the			4) Monitoring for outcomes of		
		sandwiches containing			established plan and involvement of		
		yonnaise were to be stored			facility QAA/QAPI committee:		
	-	ore serving, and kept above			A. Dietary Manager, designee, will	-	
		ident trays were being			compliance outcomes and any correct	tive	
	prepared.				action needed to the morning administrative meeting for team revie	\ A /	
	At 10:04 AM on 11/19	9/15 a dietary employee,			weekly X 8 weeks.	**	
		s included food preparation,			B. Dietary Manager, designee, will	oring	
		lieve preparing salads made			compliance outcomes to facility QAA	Ŭ	
		the same day they were			meeting on a monthly basis X 3 mont		
		them to cool down enough			followed by quarterly for 3 quarters, a		
	-	reported on 11/18/15 she			as needed for QAA committee memb	ers	
	-	nts in preparing the tuna ed the sandwiches as soon			to review and make any necessary revisions to the plan as needed.		
		bled. She commented that if			C. Discussion of outcomes, root car	ISP	
		ach 41 degrees Fahrenheit			analysis for non-compliance, and any		

Facility ID: 943524

						0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY		
						C		
		345380	B. WING		11/	11/20/2015		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
THE REH	AB AND HC CTR AT VILL	AGE GR		1601 PURDUE DRIVE FAYETTEVILLE, NC 28304				
(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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 371 Continued From page 24		e 24	F 37	1				
	for a couple of hours making residents sick	there was a potential for		revisions to the outlined plar included in the QAA meeting D. Any revision to the plan	minutes.			
	stacked on top of one	18/15 10 of 12 tray pans, a another in storage, had de of them. At this time the		applicable dietary staff to be by Dietary Manager, designed monitoring cycle to begin ag	re-inserviced ee, and for the			
	kitchen manager (KM the tray pans had be	I) stated he thought some of en stacked in storage last been added this morning.		4A.				
	At 9:13 AM on 11/19/	15 the KM stated employees						
	should be free of food	viously that kitchenware d particles and dry before one another in a storage						
	there was not a lot of The KM also comme	art of the problem was that room to air dry kitchenware. nted trapped moisture could nad the potential of making						
	stated all dietary staff during which staff we kitchenware had to b	9/15 a dietary employee f had attended in-services re instructed that e clean and dry before						
		18/15 a dietary employee h over the meat sink.						
		15 mayonnaise, onion, and						
	boiled egg were adde tuna fish. At this time	ed to a large bowl containing the employee making the would be using a spray						
	completed the salad	preparation.						
	bucket was used to w	15 a cloth from a green vipe down the food ere the tuna salad was						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 04/20/2017 1 APPROVED 2: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345380	B. WING		-	(11/:	; 20/2015
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
			1	601 PURDUE DRIVE			
THE REHA	AB AND HC CTR AT VILL	AGE GR	F	AYETTEVILLE, NC 283	04		
(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 TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page assembled.	25	F 371				
	wiping down a food p	15 the cook was observed reparation cart/table and the th a cloth from a green					
	meal carts which had dining room were em wiped down the inside	d 9:52 AM on 11/18/15 three been on the halls and in the otied. A dietary employee e and outside of the carts e obtained from a tub of dish re dirty utensils were					
	(KM) stated the green contained a dishwash he was unsure wheth in the kitchen contain sanitizing solution. H when the spray bottle used to check the stre and quarternary solut placed in the solution bottles (including the	15 the kitchen manager buckets in the kitchen ing solution. He reported er the three sanitizer bottles ed bleach or quaternary e was also unsure about s had been made up. Strips ength of both bleach-based ions failed to register when s inside 2 of the 3 spray spray bottle utilized in the ish salad was prepared).					
	station should have a bottle containing quar He reported all food p kitchen should be sar preparation tasks. Th should be used after buckets to make sure 150 - 200 parts per m According to the KM,	15 the KM stated every work red bucket and a spray ternary sanitizing solution. reparation surfaces in the hitized between completing the KM commented strips making up the bottles and the solutions registered illion of sanitizer. the spray bottles and red anged out twice daily. He					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				INTED: 04/20/2017 FORM APPROVED IB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION) DATE SURVEY COMPLETED
		345380	B. WING			C 11/20/2015
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STAT	E, ZIP CODE	
			1	601 PURDUE DRIVE		
THE REHA	AB AND HC CTR AT VILL	AGE GR	F	AYETTEVILLE, NC 28304	4	
(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	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page	26	F 371			
	stated a quarternary s supposed to be used which returned from t where germs and bac picked up.	sanitizing solution was for wiping down meal carts he halls and dining room steria could have been				
	stated she did not rec down meal carts with However, she reporte bottles were made up quarternary solution of three-compartment si	d red buckets and spray twice daily, and contained lispensed from the nk system. She stated work sed to be sanitized after				
	9:50 AM on 11/16/15, machine were coated dust. In addition, a th patches of dust were	in a thick film of grease and ick film of grease and observed on the seven filter ove/oven system. The owave oven was also				
		ar of the kitchen at 8:50 AM top of the microwave oven to food particles.				
	(KM) stated the maint responsible for cleani and the hood system. employees in the diet both types of filters if dirty between the sch The KM commented of machine could contar	15 the kitchen manager renance department was ng the ice machine filters However, he reported ary department cleaned they became greasy and eduled maintenance times. dirty filters on the ice ninate the ice and effect the the ice machine. He also				

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	-	ID 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
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE REH	AB AND HC CTR AT VILL	AGE GR			601 PURDUE DRIVE AYETTEVILLE, NC 28304		
(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 371	contaminate the food greasy filters posed at the KM, the inside bo microwave were supp daily to prevent dried food which was being At 9:28 AM on 11/19/ manager (MM) stated making sure the hood every six months, but employees cleaned th at least every month a build up of grease and fires and contaminate cleaned kitchen filters thought dietary slid ou weekly and as neede prevent contamination functioning of the mad At 10:04 AM on 11/19 stated the facility had some tasks to be don some monthly. Howe employees mainly cle would either notify mat themselves if they be reported employees u supposed to wipe it d the end of their shift. could fall off the inside contaminate food whi 6. During initial tour, 11/16/15, bags of pot eggplant in the reach	a above the stove could cooking below them, and fire hazard. According to thom, sides, and top of the posed to be cleaned at least food from falling into fresh heated. 15 the maintenance he was responsible for l system was deep cleaned he thought dietary re filters in the stove system and as needed to prevent a d dust which could cause food. The MM reported he s/vents monthly, but he ut the ice machine filters d to keep them clean to n to ice and promote optimal chine. 0/15 a dietary employee a cleaning schedule with e daily, some weekly, and ever, she stated the dietary taned up as they went, and aintenance or clean filters came dirty and greasy. She using the microwave were own after use or at least by She commented dried food e top of the microwave and ch was heating. beginning at 9:50 AM on	F	371			

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TATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING			TE SURVEY MPLETED
		345380	B. WING		C 11/20/2015	
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
THE REH	AB AND HC CTR AT VIL	LAGE GR		PURDUE DRIVE ETTEVILLE, NC 28304		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	CTION SHOULD BE COM O THE APPROPRIATE	
F 371 F 425 SS=E	dressing, mayonnais cheese dressing, rar sauce, Italian dressin dressing were opened open dates. In the box of cornbread mix mix, a bag of croutor wafers were opened dates. In the walk-in cob and sliced eggp labels and dates. At manager (KM) states items should be date reported, however, h wrote on containers were received into th At 10:04 AM on 11/1 stated prior to the su on food items were to foods arrived in the for reported it made ser date to make sure the opened earliest were would stay as fresh 483.60(a),(b) PHAR ACCURATE PROCE The facility must pro drugs and biological them under an agree §483.75(h) of this par	 ontainers of Tuscan Caesar se, French dressing, blue nch dressing, barbecue ng, and honey mustard ed but without labels and dry storage room a 5-pound x, two 5-pound bags of cake ns, and a bag of vanilla but without labels and open n freezer bags of corn on the lant were opened but without t this time the kitchen d he was not aware that food ed when opened. He ne was making sure the staff of food the dates when they ne facility. 9/15 a dietary employee urvey the only dates recorded the receipt dates when the facility. However, she nse to also document an open nose foods which were e used up first so everything as possible. MACEUTICAL SVC - EDURES, RPH vide routine and emergency s to its residents, or obtain ement described in at. The facility may permit el to administer drugs if State y under the general 	F 371			12/18/15

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	-	ND HUMAN SERVICES			PRINTED: 04/20/2017 FORM APPROVED OMB NO: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345380	B. WING		C 11/20/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THE REHA	AB AND HC CTR AT VILI	AGE GR		1601 PURDUE DRIVE FAYETTEVILLE, NC 28304	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 425	acquiring, receiving, administering of all di the needs of each res The facility must emp a licensed pharmacis	s that assure the accurate dispensing, and rugs and biologicals) to meet sident. bloy or obtain the services of st who provides consultation provision of pharmacy	F 425		
	by: Based on observation pharmacy staff interval and record review, the established procedur narcotic medications (Resident #46, #45, # #21 and #177) receive Findings included: 1. A review of the fact Ordering and Receive Pharmacy-Emergence Emergency Kits " (da 2015) included a sect Medications are not be residents. " The order either from the emerged dispensing system (A pharmacy or a back-to determined by the pro- Resident # 46 was action	iew, physician interviews e facility failed to follow es for the acquisition of for 9 of 37 residents #121, #33, #160, #270, #56, ring controlled substances. ility policy titled "Medication ing from ey Pharmacy Services and ated as effective June 9, tion titled, Procedures: E. " porrowed from other ered medication is obtained gency box or automated ADS), from the provider up pharmacy that is povider pharmacy.		F 425: 483.60(a)(b) PHARMACEUTIC SERVICES ACCURATE PROCEDUR RPH 1) Actions taken for Residents #46, #121, #33, #160, #270, #56, #21, #17 A. Borrowed medications for resider listed above: Klonopin, Xanax, Oxycodone, Ativan B. On/before 12/18/2015 contracted pharmacy contacted by the facility administrator for reconciliation of med costs for each involved resident costs for each involved resident costs for each involved resident cost for each involved resident cost for each involved resident cost for facility covered the cost of the medication as needed. C. Involved licensed nurses were re-inserviced on 11/19/2015 by the fac DON on Medication Ordering and Receiving from Pharmacy Pharmacy Services and Emergency K 2) Actions taken for all residents due the potential for being affected:	RES, #45, 7 hts sts dent cility hcy fits. e to
	7/27/15. A review of t	he resident ' s medical ication orders included the		A. All residents have the potential to affected	be

Facility ID: 943524

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) D	NO. 0938-03 ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CC	OMPLETED
			5.14/11/0			С
		345380	B. WING			11/20/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
THE REH	AB AND HC CTR AT VILI	LAGE GR		1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETIO
F 425	Continued From page	e 30	F 42	25		
	following: Klonopin 0	.5 milligrams (mg) to be		B. On/before 12/18/2015,	facility DON	
	U U U	eat schizophrenia originally		reviewed all narcotic count	•	
	ordered 9/26/15.			borrowing of medications fr		
				to be given to other residen		
		#46 ' s Controlled Drug		without ordered medication		
		Klonopin was signed out by		C. All licensed nursing pe		
		s "borrowed for (Resident		re-inserviced on/before 12/	•	
	#29) " .			DON, appropriate designee	e with regards	
	In an interview on 11	/18/15 at 2:05 PM, the		(1) Against facility policy to	borrow	
		st stated she was not aware		medications from residents		
		borrowing narcotics. She		residents		
		does the medication reviews		(2) Facility policy for Medi	cation Ordering	
		cation carts and ADS issues		and Receiving from Pharma		
	to either the pharmad	cy technician or the nurse		Emergency Pharmacy Serv	vices and	
	consultant.			Emergency Kits		
				(3) Process for re-ordering		
		on 11/18/15 at 2:17 PM, the		timely through electronic or	• •	
		he ADS " crashed " on		(4) Process for obtaining h		
		aware it went off line a few		timely for Schedule II narco		
	-	ne system went offline, the		(5) Process for obtaining r		
		see what needed reordering d from the ADS. It does not		from the in-house dispensir (6) The process for comm		
		y to get medications out of		unresolved issues or conce	•	
		the pharmacist. She		included in the above refere		
	-	cy calling the facility and		and emphasized in the facil		
		sages for the director of		programming.		
		ne unit manager (UM) to		(7) Any nursing personnel		
		se the pharmacy was unable		attendance will be contacte	-	
	-	. She stated the pharmacy		or appropriate designee, ar	-	
	-	f the ADS and made them		information prior to the emp	ooyee⊡s next	
		erns on 11/4/15 but then the		scheduled shift.	nt furthor	
	ADS crashed. The pl	at arrived at the facility on		 Actions taken to prevent recurrence: 		
	-	y did have backup pharmacy		A. In addition to the re-ins	servicing stated	
	services in the interin			in Section 2, the contracted	-	
				pharmacist held an inservic		
	In an interview on 11	/18/15 at 2:45 PM, the DON		12/16/2015 with licensed n		
		n problems recently with the		personnel regarding pharm	•	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/20/201 FORM APPROVEI OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345380	B. WING		C 11/20/2015
NAME OF P	ROVIDER OR SUPPLIER	·	•	STREET ADDRESS, CITY, STATE, ZIP CODE	•
THE REH	AB AND HC CTR AT VILL	AGE GR		1601 PURDUE DRIVE FAYETTEVILLE, NC 28304	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 425	ADS and she had to machine but it was renewally and she that to machine but it was renewally and she that the DON stated once the orders were faxed and when the resider paper prescription it was paper prescription it was paper prescription it was the DON verified the medications to the fact off time to get me was 5:00 PM. She also backup pharmacy in twas needed prior to the medication at midnight in an interview on 111, identified her signatu. Record as having both Resident #46 for Rest acknowledged she has substances on other stated she was aware borrowing controlled physician only came prescriptions for refills option. Nurse #4 state were issues with the the backup pharmacy prescription. She state physician and get or medication in some if medication in some if medication such for stated anytime a medication such physician should be reformed as the physician should be reformed as	repeatedly reset the eplaced the first part of nought it was working better. e an admission was verified, d to the facility pharmacy nt arrived with the original would be placed in the delivered to the pharmacy. e pharmacy delivered cility around midnight and dications the same night so stated the facility utilized a the event that a medication the arrival of the ordered ht. /18/15 at 4:40 PM, Nurse #4 re of the Control Drug rrowed Klonopin from ident #29. She ad borrowed control occasions as well. Nurse #4 e of the facility policy against medications but the on the weekends and wrote s and she was left with little ed she was aware there ADS and she could not use y without a physician signed ted she could call the bers for an alternate nstance but not for some her residents. Nurse #4 dication was unavailable the notified and she felt some	F 42	 for re-ordering medications, acquirimedications from the in-house dispsystem, and the potential errors whe medications are borrowed from res B. Any nursing personnel not in attendance will be contacted by the or appropriate designee, and given information prior to the employee scheduled shift. C. On/before 12/18/15, licensed right personnel will be instructed to note problems with the in-house dispensimedication system on the nursing 2 report for next day follow-up by the or designee. D. Facility DON, or appropriate designee, will review narcotic courrisheets for the any incidents of borromedications from residents as follor (1) Daily for 3 days/week X 2 wee followed by (2) Weekly X 6 weeks, followed by (3) Quarterly X 2 quarters , (4) And as needed E. Any incident found for borrowing be addressed with the licensed nurriesponsible by DON, or designee, for a day subsequent counseling a needed. 4) Monitoring for outcomes of established plan and involvement of facility QAA/QAPI committee: A. Results of narcotic sheet monit and any problems noted on the 24 nursing regarding the in-house meed dispensing system will be brought to DON, designee, to the morning administrative meeting and reviewer the administrative team weekly X 8 	ensing idents a DON, the s next hursing any sing 24 hour DON, t wing ws: ks, y ng will se for root as of toring hour dication by

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/20/20 FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345380	B. WING		C 11/20/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				1601 PURDUE DRIVE	
THE REH	AB AND HC CTR AT VILL	LAGE GR		FAYETTEVILLE, NC 28304	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO
F 425	card, that was when it trying to obtain anoth a nurse waited until a area, it would be too prescriptions and hav resident. Nurse #4 st facility for approximal already identified the because she was told problem and manage In a telephone intervit the long term care unt to the facility on Satu stated staff normally narcotic refill and put week before he come medication during we prescription at his off pharmacy. He stated with resident 's gettir In an interview on 11/ rehabilitation unit phy the facility had an AD in emergencies and it when a resident 's na the blue area on the p ample time to get a re the facility at minimur verified that he could prescriptions if he was In a telephone intervit the pharmacy technic internet based but it of the whether or not it w acknowledged the ph	normally a nurse should start er written prescription but if a medication was in the blue late to get a new ve the refill available for the ated she had worked at the tely 2 weeks but she had issue but did not report it d it had been an ongoing ement was aware. ew on 11/19/15 at 9:48 AM, hit physician stated he came rdays and Sundays. He anticipate a need for a the order in his box the es. If a resident needed a eek, he could write ice and fax it to the he had never had any issue ng their narcotics as ordered. (19/15 at 10:25 AM, the visician assistant (PA) stated VS that should only be used f staff notified him timely arcotic medications were in punch card, there should be efill. The PA stated he was at m 2-3 times weekly and email the pharmacy us made aware of a need. ew on 11/19/15 at 11:08 AM, cian stated the ADS was could be accessed at facility	F 42		hour dication to the A arterly blished Pl ed evisions in the hed entions f by the l plan again

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	-	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	
		345380	B. WING				_ 20/2015
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
THE REH	AB AND HC CTR AT VILL	AGE GR			1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 425	technician she was all reset the machine but aware of crashed all the technician stated she was borrowing narcoth not review the Control checked that medicath medications during he In a telephone intervite the pharmacy nurse of monthly facility visit, si medication carts for en- stated she was unawe having any narcotic bo made aware until yes replaced earlier this in consultant stated she responsible for the re Records to ensure the narcotic borrowing. Si reviewed the Control but if she noted any pr addressed in her more facility. A review of the Medice Report dated 8/21/15 completed by the phather pharmacy technic review of the Control In an observation on was attempting to retu- supplemental potassi ADS. The UM attemp never would open to a from the ADS. After the	the facility on 10/28/15 and ton 11/5/15, she was made together. The pharmacy was not aware the facility ics but she normally does I Drug Records but rather ion carts for expired er monthly visits. ew on 11/19/15 at 11:15 AM, consultant stated during her she " spot checks " the expired medications. She are that the facility was orrowing issues and was not terday, the ADS had to be nonth. The pharmacy nurse was uncertain who was view of the Control Drug ere was no evidence of he acknowledged she had Drug Records in the past problems, it would have been nothly visit report given to the eration Room Compliance , 9/15/15 and 10/28/15 irmacy nurse consultant and ian did not reference a	F	425			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		345380	B. WING				C 20/2015
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE REH	AB AND HC CTR AT VILL	AGE GR			1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 425	to follow up with the c malfunction. In an interview on 11/ stated the pharmacist and she was unsure of malfunction earlier wite expectation of the DC narcotic medications rather utilize the back 2. A review of the fact Ordering and Receivin Pharmacy-Emergence Emergency Kits " (da 2015) included a sect Medications are not b residents. " The orde either from the emerge dispensing system (A pharmacy or a back-ud determined by the pro- Resident # 45 was ad 9/2915. A review of the record revealed media following: Xanax 0.25 every 6 hours as need ordered 10/1/15. A review of Resident 7 nurse and noted as " #29) ". In an interview on 11/	The pharmacist was asked butcome of the ADS (19/15 at 4:50 PM, the DON t was no longer at the facility of the outcome of the ADS thessed. It was the DN that the facility not borrow under any circumstance but trup pharmacy or the ADS. (i) the pharmacy or the ADS. (i) the outcome of the ADS. (i) the facility not borrow under any circumstance but trup pharmacy or the ADS. (i) the outcome of the ADS. (i) the outcome of the ADS. (i) the facility not borrow under any circumstance but trup pharmacy or the ADS. (i) the facility not borrow (i) the facility not borr	F	425			
	ordered 10/1/15. A review of Resident : Record revealed her 2 nurse and noted as " #29) " . In an interview on 11/ consultant pharmacis	#45 ' s Controlled Drug Xanax was signed out by a borrowed for (Resident 18/15 at 2:05 PM, the					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/20/2017 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345380	B. WING				C / 20/2015
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				16	601 PURDUE DRIVE		
	AB AND HC CTR AT VILL	AGE GR		F/	AYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	and leaves the medic to either the pharmac consultant. In an interview on 11/ stated she was aware policy but she acknow Control Drug Record the past. Nurse #7 sta problem for " awhile " the physician before t narcotics. She stated problem and everyone stated there was ongo ADS. She stated there and it was never resto In another interview o pharmacist recalled the 11/5/15 and she was days before. When the pharmacy could not s	oes the medication reviews ation carts and ADS issues y technician or the nurse 18/15 at 2:05 PM, Nurse # 7 e it was against the facility vledge her signature on the and borrowing narcotics in ated the facility has had a ' getting prescriptions from he residents ran out of everyone has the same e knows about it. Nurse #7 bing issues with the facility e was problems accessing it bocked. n 11/18/15 at 2:17 PM, the ne ADS " crashed " on aware it went off line a few e system went offline, the ee what needed reordering	F 4	.25			
	limit the staff 's ability the ADS according to recalled the pharmacy leaving multiple mess nursing (DON) and th reset the ADS becaus to view the inventory. called the provider of aware of offline conce ADS crashed. The ph replacement ADS that 11/7/15 but the facility services in the interim	y calling the facility and ages for the director of e unit manager (UM) to se the pharmacy was unable She stated the pharmacy the ADS and made them erns on 11/4/15 but then the armacy ordered a t arrived at the facility on y did have backup pharmacy					

Facility ID: 943524

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/20/2017 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE REHA	AB AND HC CTR AT VILL	AGE GR			601 PURDUE DRIVE AYETTEVILLE, NC 28304		
(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 425	stated there had beer ADS and she had to r machine but it was re November and she th The DON stated once the orders were faxed and when the residen paper prescription it w pharmacy tote to be of The DON verified the medications to the fac cut off time to get mee was 5:00 PM. She als backup pharmacy in t was needed prior to th medication at midnigh In a telephone intervie the long term care un to the facility on Satur stated staff normally a narcotic refill and put week before he come medication during we prescription at his offi pharmacy. He stated with resident 's gettin In an interview on 11/ rehabilitation unit phy the facility had an AD in emergencies and if when a resident 's na the blue area on the p ample time to get a re the facility at minimum verified that he could	n problems recently with the repeatedly reset the placed the first part of hought it was working better. e an admission was verified, d to the facility pharmacy at arrived with the original would be placed in the delivered to the pharmacy. pharmacy delivered cility around midnight and dications the same night so stated the facility utilized a the event that a medication he arrival of the ordered nt. ew on 11/19/15 at 9:48 AM, it physician stated he came rdays and Sundays. He anticipate a need for a the order in his box the es. If a resident needed a ek, he could write ice and fax it to the he had never had any issue ing their narcotics as ordered. (19/15 at 10:25 AM, the sician assistant (PA) stated S that should only be used f staff notified him timely arcotic medications were in bunch card, there should be efill. The PA stated he was at in 2-3 times weekly and	F	425			

Facility ID: 943524

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILD	ING .			
		345380	B. WING				_ 20/2015
NAME OF P	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE REH	AB AND HC CTR AT VILL	AGE GR			1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 425	In a telephone intervie the pharmacy technic internet based but it of the whether online or the pharmacy could n unless it was online. T she was at the facility machine but on 11/5/ crashed all together. T stated she was not aw borrowing narcotics b review the Control Dr checked that medicat medications during he In a telephone intervie the pharmacy nurse of monthly facility visit, s medication carts for e stated she was unawa having any narcotic b made aware until yes replaced earlier this n consultant stated she responsible for the re Records to ensure the narcotic borrowing. S reviewed the Control but if she noted any p addressed in her mor facility. A review of the Medic Report dated 8/21/15 completed by the pha the pharmacy technic review of the Control	ew on 11/19/15 at 11:08 AM, ian stated the ADS was could be accessed at facility offline. She acknowledged ot log in to refill the ADS The pharmacy technician on 10/28/15 and reset the 15, she was made aware of The pharmacy technician ware the facility was ut she normally does not ug Records but rather ion carts for expired er monthly visits. ew on 11/19/15 at 11:15 AM, consultant stated during her she " spot checks " the xpired medications. She are that the facility was orrowing issues and was not terday, the ADS had to be nonth. The pharmacy nurse was uncertain who was view of the Control Drug ere was no evidence of he acknowledged she had Drug Records in the past roblems, it would have been attin Room Compliance , 9/15/15 and 10/28/15 rmacy nurse consultant and ian did not reference a	F	425			

Facility ID: 943524

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	
THE REH	AB AND HC CTR AT VILL	AGE GR			1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 425	supplemental potassi ADS. The UM attemp never would open to a from the ADS. After th and got the consultant facility for assistance. to follow up with the of malfunction. In an interview on 11/ stated the pharmacist and she was unsure of malfunction earlier wite expectation of the DC narcotic medications rather utilize the back 3. A review of the fact Ordering and Receivi Pharmacy-Emergenc Emergency Kits " (da 2015) included a sect Medications are not b residents. " The orde either from the emerg dispensing system (A pharmacy or a back-u determined by the pro- Resident # 121 was a 5/1/15. A review of the revealed medication of following: Klonopin 0. times daily for anxiety A review of Resident Record revealed her	rieve a onetime dose of um for a resident from the sted three times but the ADS allow retrieve the potassium he third attempt, she went at pharmacist who was in the . The pharmacist was asked butcome of the ADS (19/15 at 4:50 PM, the DON t was no longer at the facility of the outcome of the ADS thessed. It was the DN that the facility not borrow under any circumstance but sup pharmacy or the ADS. (19/15 pharmacy or the ADS) thessed. It was the DN that the facility not borrow under any circumstance but sup pharmacy or the ADS. (19/15 pharmacy Services and ated as effective June 9, tion titled, Procedures: E. " borrowed from other ered medication is obtained gency box or automated DS), from the provider up pharmacy that is bovider pharmacy. (admitted to the facility on e resident ' s medical record	F	42	5		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/20/2017 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			-	(X3) DATE COMP	SURVEY LETED
		345380	B. WING				C 20/2015
NAME OF PR	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
				1601 PURDUE DRIVE			
THE REHA	AB AND HC CTR AT VILL	AGE GR		FAYETTEVILLE, NC 28	304		
(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 425	Continued From page #46) " .	9 39	F 42	5			
	In an interview on 11/ consultant pharmacis that the nurses were it stated she primarily d and leaves the medic to either the pharmac consultant. In an interview on 11/ stated she was aware policy but she acknow Control Drug Record the past. Nurse #7 sta problem for " awhile" the physician before t narcotics. She stated problem and everyone stated there was ong ADS. She stated there and it was never resto In another interview o pharmacist recalled th 11/5/15 and she was days before. When th pharmacy could not s or what is being used limit the staff ' s ability the ADS according to recalled the pharmacy leaving multiple mess	t stated she was not aware borrowing narcotics. She oes the medication reviews ation carts and ADS issues y technician or the nurse 18/15 at 2:05 PM, Nurse # 7 e it was against the facility vledge her signature on the and borrowing narcotics in ated the facility has had a " getting prescriptions from he residents ran out of everyone has the same e knows about it. Nurse #7 bing issues with the facility e was problems accessing it bocked. In 11/18/15 at 2:17 PM, the ne ADS " crashed " on aware it went off line a few e system went offline, the ee what needed reordering from the ADS. It does not y to get medications out of					
	to view the inventory. called the provider of	se the pharmacy was unable She stated the pharmacy the ADS and made them erns on 11/4/15 but then the armacy ordered a					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345380	B. WING			CTION DMB NO. (X3) DATE SI COMPLE C 11/20	C 20/2015
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
THE REH	AB AND HC CTR AT VILL	AGE GR			1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(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 425	replacement ADS tha 11/7/15 but the facility services in the interim In an interview on 11/ stated there had beer ADS and she had to machine but it was re November and she the The DON stated once the orders were faxed and when the resider paper prescription it w pharmacy tote to be of The DON verified the medications to the fac cut off time to get me was 5:00 PM. She als backup pharmacy in the was needed prior to the medication at midnigh In a telephone interviti the long term care un to the facility on Satur stated staff normally a narcotic refill and put week before he come medication during we prescription at his offi pharmacy. He stated with resident 's gettir In an interview on 11/ rehabilitation unit phy the facility had an AD in emergencies and if when a resident 's na	t arrived at the facility on y did have backup pharmacy h. 18/15 at 2:45 PM, the DON in problems recently with the repeatedly reset the placed the first part of rought it was working better. A an admission was verified, d to the facility pharmacy the arrived with the original would be placed in the delivered to the pharmacy. pharmacy delivered cility around midnight and dications the same night so stated the facility utilized a the event that a medication he arrival of the ordered nt. ew on 11/19/15 at 9:48 AM, it physician stated he came rdays and Sundays. He anticipate a need for a the order in his box the es. If a resident needed a ek, he could write	F	425			

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If continuation sheet Page 41 of 76

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE REH	AB AND HC CTR AT VILL	AGE GR			601 PURDUE DRIVE AYETTEVILLE, NC 28304		
(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 425	ample time to get a re the facility at minimum verified that he could prescriptions if he wa In a telephone intervie the pharmacy technic internet based but it of the whether or not it w acknowledged the ph refill the ADS unless i technician she was at reset the machine but aware of crashed all t technician stated she was borrowing narcot not review the Contro checked that medicat medications during he In a telephone intervie the pharmacy nurse of monthly facility visit, s medication carts for e stated she was unaw having any narcotic b made aware until yes replaced earlier this n consultant stated she responsible for the re Records to ensure the narcotic borrowing. S reviewed the Control but if she noted any p addressed in her mor facility. A review of the Medic	efill. The PA stated he was at n 2-3 times weekly and email the pharmacy s made aware of a need. ew on 11/19/15 at 11:08 AM, tian stated the ADS was could be accessed at facility was online. She armacy could not log in to t was online. The pharmacy t the facility on 10/28/15 and t on 11/5/15, she was made together. The pharmacy was not aware the facility tics but she normally does of Drug Records but rather ion carts for expired	F	425			

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		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE REH	AB AND HC CTR AT VILL	AGE GR			601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 425	completed by the pha the pharmacy technic review of the Control In an observation on was attempting to retri- supplemental potassi ADS. The UM attemp never would open to a from the ADS. After the and got the consultant facility for assistance. to follow up with the or malfunction. In an interview on 11/ stated the pharmacist and she was unsure or malfunction earlier wite expectation of the DC narcotic medications is rather utilize the back 4. A review of the faci Ordering and Receivite Pharmacy-Emergence Emergency Kits " (da 2015) included a sect Medications are not b residents. " The orde either from the emerged dispensing system (A pharmacy or a back-ud determined by the pro-	rmacy nurse consultant and ian did not reference a Drug Record sheets. 11/19/15 at 2:45 PM, the UM rieve a onetime dose of um for a resident from the ted three times but the ADS allow retrieve the potassium ne third attempt, she went t pharmacist who was in the The pharmacist was asked butcome of the ADS 19/15 at 4:50 PM, the DON was no longer at the facility of the outcome of the ADS thessed. It was the DN that the facility not borrow under any circumstance but up pharmacy or the ADS. lity policy titled " Medication ng from y Pharmacy Services and ted as effective June 9, ion titled, Procedures: E. " orrowed from other red medication is obtained ency box or automated DS), from the provider up pharmacy that is	F	425			

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	-	D HUMAN SERVICES MEDICAID SERVICES				RINTED: 04/2 FORM APPF MB NO. 0938	ROVED
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		X3) DATE SURVE COMPLETED	
		345380	B. WING			C 11/20/201	5
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE,	, ZIP CODE		
			1	601 PURDUE DRIVE			
THE REHA	AB AND HC CTR AT VILL	AGE GR	F	AYETTEVILLE, NC 28304			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)	COMP	(5) LETION ATE
F 425			F 425				
		borrowed for (Resident					
	consultant pharmacis that the nurses were b stated she primarily d and leaves the medic	t stated she was not aware porrowing narcotics. She oes the medication reviews ation carts and ADS issues y technician or the nurse					
	pharmacist recalled th 11/5/15 and she was days before. When th pharmacy could not s or what is being used limit the staff 's ability the ADS according to recalled the pharmacy leaving multiple mess nursing (DON) and th reset the ADS becaus to view the inventory. called the provider of aware of offline conce ADS crashed. The ph replacement ADS tha 11/7/15 but the facility services in the interim	y calling the facility and ages for the director of e unit manager (UM) to se the pharmacy was unable She stated the pharmacy the ADS and made them erns on 11/4/15 but then the armacy ordered a t arrived at the facility on o did have backup pharmacy t.					
	stated there had been ADS and she had to r	18/15 at 2:45 PM, the DON problems recently with the epeatedly reset the placed the first part of					

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CENTERS FOR MEDICALE & MEDICALD SERVICES OME NO. 0938-0391 STATUENT OF DEPICIENCES (X) PROVIDER SUPPLIERCIUM IDENTIFICATION NUMBER: (X) MULTIPLE CONSTRUCTION A BUILDING (X) BOY OF DEPICIENCES NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE REHAB AND HC CTR AT VILLAGE GR SUMMARY STATEMENT OF DEPICIENCES IN PREPIX SUMMARY STATEMENT OF DEPICIENCES IN FULL RESULTORY ON LGS DENTIFIENCE INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE THE REHAB AND HC CTR AT VILLAGE GR PREPIX SUMMARY STATEMENT OF DEPICIENCES IN FULL RESULTORY ON LGS DENTIFIENCE INFORMATION) THE REHAB AND HC CTR AT VILLAGE GR PREPIX SUMMARY STATEMENT OF DEPICIENCES IN FULL RESULTORY ON LGS DENTIFIENCE INFORMATION) THE REHAB AND HC CTR AT VILLAGE GR PREVIDENTIFIENCE INFORMATION THE REHAB AND HC CTR AT VILLAGE GR SUMMARY STATEMENT OF DEPICIENCES THE REHAB AND HC CTR AT VILLAGE GR PREVIDENTIFIENCE INFORMATION THE DON STREET ADDRESS, CITY, STATE, ZIP CODE THE DON STREET ADDRESS CONTON TOWN BALLAGE OR THE DON STREET ADDRESS			ID HUMAN SERVICES			F	NTED: 04/20/2017 FORM APPROVED B NO. 0938-0391
345380 Introduction Introduction NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE REHAB AND HC CTR AT VILLAGE GR STREET ADDRESS, CITY, STATE, ZIP CODE (04) ID SUMMARY STATEMENT OF DEFICIENCES ID PRECINE DEFICIENCE STREET ADDRESS, CITY, STATE, ZIP CODE (04) ID SUMMARY STATEMENT OF DEFICIENCES ID PRECINT CONCERSES CONFLICTION (00) (04) ID SUMMARY STATEMENT OF DEFICIENCES ID PRECINT CONCERTENCE OT THE APPROPRIATE DEFICIENCY WAS TO LD BE (74) ID SUMMARY STATEMENT OF DEFICIENCES ID PRECINT CONCERTENCE OT THE APPROPRIATE DEFICIENCY ON LD BE F 425 Continued From page 44 F 425 FACE DE DE BE November and she thought it was working better. The DON verified the pharmacy and when the resident arrived with the original paper prescription it would be placed in the pharmacy to the be adelivered to the facility utilized a backup pharmacy in the event that a medication was needed prior to the arrival of the ordered medications to the facility utilized a backup pharmacy in the event that a medication was needed prior to the arrival of the ordered medication at midnight. In an interview on 11/18/15 at 4:40 PM, Nurse #4 stated she was aw	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,		(X3)	DATE SURVEY COMPLETED
THE REHAB AND HC CTR AT VILLAGE GR 1601 PURDUE DRIVE FAYETTEVILLE, NC 28304 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOLD BE (EACH CORRECTIVE ACTION SHOLD BE REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE (EACH CORRECTIVE ACTION SHOLD BE OROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) COMPETION (DATE F 425 Continued From page 44 November and she thought it was working better. The DON stated once an admission was verified, the orders were faxed to the facility pharmacy and when the resident arrived with the original paper prescription it would be placed in the pharmacy tote to be delivered to the pharmacy. The DON verified the pharmacy delivered medications to the facility around midnight and cut off time to get medications the same night was 5:00 PM. She also stated the facility utilized a backup pharmacy in the event that a medication was needed prior to the arrival of the ordered medication at midnight. In an interview on 11/18/15 at 4:40 PM, Nurse #4 identified her signature of the Control Drug Record as having borrowed Klonopin from Resident #46 for Resident #29. She acknowledged she had borrowed control substances on other occasions as well. Nurse #4 isted she was aware of the facility policy against borrowing controlled medications but the physician only came on the weekends and wrote prescriptions for refils and she was left with little option. Nurse #4 stated she was aware there			345380	B. WING _			-
THE REHAB AND HC CTR AT VILLAGE GR FAYETTEVILLE, NC 28304 IMAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST EPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETIFYING PROVIDER'S PLAN OF CORRECTION BIOLID BI (CONDERCITIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (ACH DEPRECIPACY OR LSC IDENTIFYING INFORMATION) PRETIFY TAG PROVIDER'S PLAN OF CORRECTION SHOULD BI (CONDERCITIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (ACH DEPRECIPACE) F 425 Continued From page 44 November and she thought it was working better. The DON stated once an admission was verified, the orders were faxed to the facility pharmacy and when the resident arrived with the original paper prescription it would be placed in the pharmacy to to be delivered to the pharmacy. The DON verified the pharmacy delivered medications to the facility around midnight and cut off time to get medications the same night was 5:00 PM. She also stated the facility utilized a backup pharmacy in the event that a medication was needed prior to the arrival of the ordered medication at midnight. In an interview on 11/18/15 at 4:40 PM, Nurse #4 identified her signature of the Control Drug Record as having borrowed Klonopin from Resident #46 for Resident #28. She acknowledged she had borrowed control substances on other occasions as well. Nurse #4 stated she was aware of the facility policy against borrowing controlled medications the physician only came on the weekends and wrote prescriptions for refils and she was left with little option. Nurse #4 stated she was aware there Interview on the weekends and wrote prescriptions for refils and she was left with little option. Nurse #4 stated she was aware there </td <td>NAME OF P</td> <td>ROVIDER OR SUPPLIER</td> <td></td> <td></td> <td>STREET ADDRESS, CITY, STATE, ZI</td> <td>P CODE</td> <td></td>	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
Image: Construct of the control of the cont	THE DELL				1601 PURDUE DRIVE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 425 Continued From page 44 F 425 November and she thought it was working better. The DON stated once an admission was verified, the orders were faxed to the facility pharmacy and when the resident arrived with the original paper prescription it would be placed in the pharmacy tote to be delivered to the pharmacy. The DON wrified the pharmacy delivered medications to the facility around midinght and cut off time to get medications the same night was 5:00 PM. She also stated the facility utilized a backup pharmacy in the event that a medication was needed prior to the arrival of the ordered medication at midnight. In an interview on 11/18/15 at 4:40 PM, Nurse #4 identified her signature of the Control Drug Record as having borrowed Klonopin from Resident #46 for Resident #29. She acknowledged she had borrowed control substances on other occasions as well. Nurse #4 stated she was aware of the facility policy against borrowing controlled medications but the physician only came on the weekends and wrote prescriptions for refils and she was left with little option. Nurse #4 stated she was aware there		AB AND HC CTR AT VILL	AGE GR		FAYETTEVILLE, NC 28304		
November and she thought it was working better. The DON stated once an admission was verified, the orders were faxed to the facility pharmacy and when the resident arrived with the original paper prescription it would be placed in the pharmacy tote to be delivered to the pharmacy. The DON verified the pharmacy delivered medications to the facility around midnight and cut off time to get medications the same night was 5:00 PM. She also stated the facility utilized a backup pharmacy in the event that a medication was needed prior to the arrival of the ordered medication at midnight. In an interview on 11/18/15 at 4:40 PM, Nurse #4 identified her signature of the Control Drug Record as having borrowed Klonopin from Resident #46 for Resident #29. She acknowledged she had borrowed control substances on other occasions as well. Nurse #4 stated she was aware of the facility policy against borrowing controlled medications but the physician only came on the weekends and wrote prescriptions for refills and she was left with little option. Nurse #4 stated she was aware there	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE A CROSS-REFERENCED T	ACTION SHOULD BE	COMPLETION
the backup pharmacy without a physician signed prescription. She stated she could call the physician and get orders for an alternate medication in some instance but not for some medications used for her residents. Nurse #4 stated anytime a medication was unavailable the physician should be notified and she felt some nurses did not reorder the narcotics timely enough since the physician only came in on the weekends. She stated when the nurse saw the medication get into the blue area on the punch card, that was when normally a nurse should startImage: Comparison of the state	F 425	November and she th The DON stated once the orders were faxed and when the resider paper prescription it w pharmacy tote to be of The DON verified the medications to the fac cut off time to get mer was 5:00 PM. She als backup pharmacy in the was needed prior to t medication at midnigh In an interview on 11/ identified her signatur Record as having bor Resident #46 for Res acknowledged she has substances on other of stated she was aware borrowing controlled of physician only came of prescriptions for refills option. Nurse #4 state were issues with the of the backup pharmacy prescription. She state physician and get ord medication in some in medication sused for stated anytime a mer physician should be r nurses did not reorde enough since the phy weekends. She state medication get into the	hought it was working better. a an admission was verified, d to the facility pharmacy at arrived with the original would be placed in the delivered to the pharmacy. pharmacy delivered cility around midnight and dications the same night so stated the facility utilized a the event that a medication he arrival of the ordered ht. 18/15 at 4:40 PM, Nurse #4 re of the Control Drug rrowed Klonopin from ident #29. She ad borrowed control occasions as well. Nurse #4 e of the facility policy against medications but the on the weekends and wrote s and she was left with little ed she was aware there ADS and she could not use y without a physician signed ted she could call the lers for an alternate nstance but not for some her residents. Nurse #4 dication was unavailable the notified and she felt some er the narcotics timely vsician only came in on the d when the nurse saw the ne blue area on the punch	F 4	125		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345380	B. WING				C /20/2015
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
THE REH	AB AND HC CTR AT VILL	AGE GR			1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(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 F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 425	a nurse waited until a area, it would be too I prescriptions and hav resident. Nurse #4 sta facility for approximat already identified the because she was tolo problem and manage In a telephone intervit the long term care un to the facility on Satur stated staff normally a narcotic refill and put week before he come medication during we prescription at his offi pharmacy. He stated with resident 's gettin In an interview on 11/ rehabilitation unit phy the facility had an AD in emergencies and if when a resident 's na the blue area on the p ample time to get a re the facility at minimum verified that he could prescriptions if he wa In a telephone intervit the pharmacy technic internet based but it o the whether or not it w acknowledged the ph refill the ADS unless i technician she was at	medication was in the blue ate to get a new e the refill available for the ated she had worked at the ely 2 weeks but she had issue but did not report it I it had been an ongoing ment was aware. ew on 11/19/15 at 9:48 AM, it physician stated he came rdays and Sundays. He anticipate a need for a the order in his box the es. If a resident needed a ek, he could write ce and fax it to the he had never had any issue ig their narcotics as ordered. 19/15 at 10:25 AM, the sician assistant (PA) stated S that should only be used f staff notified him timely arcotic medications were in bunch card, there should be efill. The PA stated he was at n 2-3 times weekly and email the pharmacy s made aware of a need. ew on 11/19/15 at 11:08 AM, ian stated the ADS was could be accessed at facility	F	428	5		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIERCIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVEY CONFILIENCIAN BUILDING NAME OF PROVIDER OR SUPPLIER 345380 STREET ADDRESS, CITY, STATE, ZIP CODE 1601 PURDUE DRIVE FACE C (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ATON SHOLD BE RESOLUTIORY OR LSC DEENTFYING INFORMATION) ID PREFIX RESOLUTIORY OR LSC DEENTFYING INFORMATION) ID PREFIX TAG STREET ADDRESS FLAN OF CORRECTIVE AT (CONSTRECTIVE ATON SHOLD BE (CACH CORRECTIVE ATON SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OWNING (CONSTRECTIVE ATON SHOLD BE (CACH CORRECTIVE ATON SHOLD ATON SHOLD ATON (CACH CORRECTIVE ATON SHOLD		IMENT OF HEALTH AN					FORM): 04/20/2017 APPROVED). 0938-0391
345380 B. WING	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE REHAB AND HC CTR AT VILLAGE GR Idd PURDUE DRIVE PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID F 425 Continued From page 46 aware of crashed all together. The pharmacy technician stated she was not aware the facility was borrowing narcotics but she normally does not review the Control Drug Records but rather checked that medication carls for expired medications during her monthly visits. F 425 In a telephone interview on 11/19/15 at 11:15 AM, the pharmacy nurse consultant stated during her monthly facility visit, she " spot checks " the medication carls for expired medications. She stated she was unaware that the facility was having any narcotic borrowing issues and was not made aware until yesterday, the ADS had to be replaced earlier this month. The pharmacy nurse consultant stated she was not expined of narcotic borrowing. She acknowledged she had reviewed the Control Drug Records in the past but if she noted any problems, it would have been addressed in her monthly visit report given to the			345380	B. WING		_		
THE REHAB AND HC CTR AT VILLAGE GR FAYETTEVILLE, NC 28304 (K4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE (EACH OERRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 000000000000000000000000000000000000	NAME OF PI	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
THE REHAB AND HC CTR AT VILLAGE GR FAYETTEVILLE, NC 28304 (K4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE (EACH OERRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 000000000000000000000000000000000000				1	601 PURDUE DRIVE			
PREFX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLI DATE F 425 Continued From page 46 aware of crashed all together. The pharmacy technician stated she was not aware the facility was borrowing narcotics but she normally does not review the Control Drug Records but rather checked that medication carts for expired medications during her monthly visits. F 425 In a telephone interview on 11/19/15 at 11:15 AM, the pharmacy nurse consultant stated during her monthly facility visit, she " spot checks " the medication carts for expired medications. She stated she was unaware that the facility was having any narcotic borrowing issues and was not made aware until yesterday, the ADS had to be replaced earlier this month. The pharmacy nurse consultant stated she was uncertain who was responsible for the review of the Control Drug Records to ensure there was no evidence of narcotic borrowing. She acknowledged she had reviewed the Control Drug Records in the past but if she noted any problems, it would have been addressed in her monthly visit report given to the	THE REHA	AB AND HC CTR AT VILL	AGE GR			04		
aware of crashed all together. The pharmacy technician stated she was not aware the facility was borrowing narcotics but she normally does not review the Control Drug Records but rather checked that medication carts for expired medications during her monthly visits. In a telephone interview on 11/19/15 at 11:15 AM, the pharmacy nurse consultant stated during her monthly facility visit, she " spot checks " the medication carts for expired medications. She stated she was unaware that the facility was having any narcotic borrowing issues and was not made aware until yesterday, the ADS had to be replaced earlier this month. The pharmacy nurse consultant stated she was uncertain who was responsible for the review of the Control Drug Records to ensure there was no evidence of narcotic borrowing. She acknowledged she had reviewed the Control Drug Records in the past but if she noted any problems, it would have been addressed in her monthly visit report given to the	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BI		(X5) COMPLETION DATE
A review of the Medication Room Compliance Report dated 8/21/15, 9/15/15 and 10/28/15 completed by the pharmacy nurse consultant and the pharmacy technician did not reference a review of the Control Drug Record sheets. In an observation on 11/19/15 at 2:45 PM, the UM was attempting to retrieve a onetime dose of supplemental potassium for a resident from the ADS. The UM attempted three times but the ADS never would open to allow retrieve the potassium from the ADS. After the third attempt, she went and got the consultant pharmacist who was in the facility for assistance. The pharmacist was asked to follow up with the outcome of the ADS	F 425	aware of crashed all t technician stated she was borrowing narcot not review the Contro checked that medicat medications during he In a telephone intervie the pharmacy nurse of monthly facility visit, s medication carts for e stated she was unawa having any narcotic b made aware until yes replaced earlier this n consultant stated she responsible for the re Records to ensure the narcotic borrowing. S reviewed the Control but if she noted any p addressed in her mor facility. A review of the Medic Report dated 8/21/15 completed by the pha the pharmacy technic review of the Control In an observation on was attempting to retr supplemental potassi ADS. The UM attemp never would open to a from the ADS. After th and got the consultant facility for assistance.	together. The pharmacy was not aware the facility itics but she normally does of Drug Records but rather ion carts for expired er monthly visits. ew on 11/19/15 at 11:15 AM, consultant stated during her she " spot checks " the expired medications. She are that the facility was orrowing issues and was not terday, the ADS had to be nonth. The pharmacy nurse was uncertain who was view of the Control Drug ere was no evidence of he acknowledged she had Drug Records in the past oroblems, it would have been nothly visit report given to the eation Room Compliance , 9/15/15 and 10/28/15 urmacy nurse consultant and tian did not reference a Drug Record sheets. 11/19/15 at 2:45 PM, the UM rieve a onetime dose of um for a resident from the ted three times but the ADS allow retrieve the potassium he third attempt, she went it pharmacist who was in the . The pharmacist was asked	F 425				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345380	B. WING				C 20/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE REHA	AB AND HC CTR AT VILL	AGE GR			1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 425	malfunction. In an interview on 11/ stated the pharmacist and she was unsure of malfunction earlier wi expectation of the DC narcotic medications rather utilize the back 5. A review of the faci Ordering and Receivi Pharmacy-Emergenc Emergency Kits " (da 2015) included a sect Medications are not b residents. " The orde either from the emerg dispensing system (A pharmacy or a back-u determined by the pro Resident # 159 was a 9/23/15 A review of t record revealed medi following: Klonopin 0. given twice daily for a 9/24/15. A review of Resident Record revealed her f a nurse and noted as #210) " .	 (19/15 at 4:50 PM, the DON to was no longer at the facility of the outcome of the ADS thessed. It was the DN that the facility not borrow under any circumstance but to pharmacy or the ADS. (19/15 at 4:50 PM, the DON to borrow under any circumstance but to borrow under any circumstance but to pharmacy or the ADS. (19/15 at 4:50 PM, the DON to borrow under any circumstance but to borrow under any circumstance but to borrow under any circumstance but to pharmacy or the ADS. (19/15 at 4:50 PM, the DON to borrow under any circumstance but to borrow under any circumstance but to borrow under any circumstance but to pharmacy Services and ated as effective June 9, to ntitled, Procedures: E. "borrowed from other the analytication is obtained pency box or automated DS), from the provider up pharmacy that is borider pharmacy. (100 at the facility on the resident 's medical cation orders included the 5 milligrams (mg) to be anxiety originally ordered (1159 's Controlled Drug Klonopin was signed out by "borrowed for (Resident") 	F	425			
	consultant pharmacis that the nurses were	18/15 at 2:05 PM, the t stated she was not aware borrowing narcotics. She loes the medication reviews					

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If continuation sheet Page 48 of 76

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345380	B. WING				C 20/2015	
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>		
				1	601 PURDUE DRIVE			
THE REHA	AB AND HC CTR AT VILL	AGE GR		F	AYETTEVILLE, NC 28304			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE				
F 425	to either the pharmac consultant. In another interview of pharmacist recalled the 11/5/15 and she was days before. When the pharmacy could not so or what is being used limit the staff 's ability the ADS according to recalled the pharmacc leaving multiple mess nursing (DON) and the reset the ADS because to view the inventory. called the provider of aware of offline conce ADS crashed. The phe replacement ADS tha 11/7/15 but the facility services in the interime In an interview on 11/ stated there had been ADS and she had to a machine but it was re November and she the The DON stated once the orders were faxed and when the resider paper prescription it w pharmacy to to be of The DON verified the medications to the fare cut off time to get mere was 5:00 PM. She also	ation carts and ADS issues by technician or the nurse on 11/18/15 at 2:17 PM, the he ADS " crashed " on aware it went off line a few he system went offline, the see what needed reordering from the ADS. It does not y to get medications out of the pharmacist. She y calling the facility and sages for the director of he unit manager (UM) to se the pharmacy was unable She stated the pharmacy the ADS and made them erns on 11/4/15 but then the harmacy ordered a t arrived at the facility on y did have backup pharmacy n. (18/15 at 2:45 PM, the DON h problems recently with the repeatedly reset the placed the first part of hought it was working better. e an admission was verified, d to the facility pharmacy at arrived with the original would be placed in the delivered to the pharmacy. pharmacy delivered cility around midnight and dications the same night so stated the facility utilized a	F	425				
		so stated the facility utilized a the event that a medication						

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED
						С
	345380 PROVIDER OR SUPPLIER AB AND HC CTR AT VILLAGE GR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 was needed prior to the arrival of the ordered medication at midnight. In an interview on 11/18/15 at 4:40 PM, Nurse #4 identified her signature of the Control Drug Record as having borrowed Klonopin from Resident #46 for Resident #29. She acknowledged she had borrowed control substances on other occasions as well. Nurse #4 stated she was aware of the facility policy against	B. WING		1	1/20/2015	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
				1601 PURDUE DRIVE		
		LAGE GR		FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 425	Continued From page	e 49	F 42	5		
			1 72			
	In an interview on 11	/18/15 at 4:40 PM. Nurse #4				
		-				
	Record as having bo	rrowed Klonopin from				
	•					
	borrowing controlled					
	-	on the weekends and wrote				
		s and she was left with little				
		ed she was aware there				
	· ·	ADS and she could not use				
		y without a physician signed				
		ted she could call the				
	physician and get or					
		nstance but not for some				
		her residents. Nurse #4 dication was unavailable the				
	-	notified and she felt some				
		er the narcotics timelyenough				
	since the physician o	, ,				
	weekends. She state	d when the nurse saw the				
		ne blue area on the punch				
		normally a nurse should start				
		her written prescription but if				
	a nurse waited until a area, it would be too	a medication was in the blue				
		ve the refill available for the				
		ated she had worked at the				
		tely 2 weeks but she had				
	already identified the	issue but did not report it				
		d it had been an ongoing				
	problem and manage	ement was aware.				
		iou on 11/10/15 -10:40 AM				
		iew on 11/19/15 at 9:48 AM, hit physician stated he came				
	⊨ me iono term care ur	in physician stated he came	1			1

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE REH	AB AND HC CTR AT VILL	AGE GR			601 PURDUE DRIVE AYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 425	to the facility on Satur stated staff normally a narcotic refill and put week before he come medication during we prescription at his offi pharmacy. He stated with resident 's gettin In an interview on 11/ rehabilitation unit phy the facility had an AD in emergencies and if when a resident 's na the blue area on the p ample time to get a re the facility at minimum verified that he could prescriptions if he was In a telephone intervie the pharmacy technic internet based but it of the whether or not it w acknowledged the ph refill the ADS unless i technician she was at reset the machine but aware of crashed all t technician stated she was borrowing narcot not review the Contro checked that medicat medications during he In a telephone intervie the pharmacy nurse of monthly facility visit, s	rdays and Sundays. He anticipate a need for a the order in his box the ss. If a resident needed a ek, he could write ce and fax it to the he had never had any issue of their narcotics as ordered. 19/15 at 10:25 AM, the sician assistant (PA) stated S that should only be used staff notified him timely arcotic medications were in bunch card, there should be efill. The PA stated he was at n 2-3 times weekly and email the pharmacy s made aware of a need. ew on 11/19/15 at 11:08 AM, ian stated the ADS was could be accessed at facility vas online. She armacy could not log in to t was online. The pharmacy t the facility on 10/28/15 and t on 11/5/15, she was made ogether. The pharmacy was not aware the facility ics but she normally does I Drug Records but rather ion carts for expired	F	425			

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	-	ID HUMAN SERVICES				FORM	M APPROVED D. 0938-0391		
STATEMENT	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE COMF	E SURVEY PLETED					
		345380	B. WING _				C / 20/2015		
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE				
THE REH	AB AND HC CTR AT VILL	AGE GR			PURDUE DRIVE TTEVILLE, NC 28304				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 425	stated she was unaw having any narcotic b made aware until yes replaced earlier this m consultant stated she responsible for the re Records to ensure the narcotic borrowing. S reviewed the Control but if she noted any p addressed in her mor facility. A review of the Medic Report dated 8/21/15 completed by the pha the pharmacy technic review of the Control In an observation on was attempting to retu- supplemental potassi ADS. The UM attemp never would open to a from the ADS. After th and got the consultant facility for assistance. to follow up with the of malfunction. In an interview on 11/ stated the pharmacist and she was unsure of malfunction earlier wi expectation of the DO narcotic medications rather utilize the back	are that the facility was orrowing issues and was not terday, the ADS had to be nonth. The pharmacy nurse was uncertain who was view of the Control Drug ere was no evidence of he acknowledged she had Drug Records in the past oroblems, it would have been on the transformer given to the ation Room Compliance , 9/15/15 and 10/28/15 ormacy nurse consultant and tian did not reference a Drug Record sheets. 11/19/15 at 2:45 PM, the UM rieve a onetime dose of um for a resident from the ted three times but the ADS allow retrieve the potassium ne third attempt, she went at pharmacist who was in the The pharmacist was asked butcome of the ADS	F	225					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345380	B. WING				20/2015
NAME OF P	ROVIDER OR SUPPLIER	L	- I	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE REH	AB AND HC CTR AT VILL	AGE GR			1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 425	Ordering and Receivi Pharmacy-Emergenc Emergency Kits " (da 2015) included a sect Medications are not b residents. " The order either from the emerge dispensing system (A pharmacy or a back-u determined by the pro- Resident # 270 was a 11/12/15. A review of record revealed medi following: Oxycodone hours as needed for p 11/12/15. A review of Resident Record revealed her a nurse and noted as #288) " . In an interview on 11/ consultant pharmacis that the nurses were stated she primarily d and leaves the medic to either the pharmac consultant. In another interview of pharmacist recalled th 11/5/15 and she was days before. When the pharmacy could not s or what is being used limit the staff 's ability	ng from y Pharmacy Services and ated as effective June 9, tion titled, Procedures: E. " porrowed from other ered medication is obtained pency box or automated .DS), from the provider up pharmacy that is	F	425			

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 04/20/2017 ORM APPROVED NO. 0938-0391	
CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		DNSTRUCTION	(X3)	DATE SURVEY COMPLETED	
		345380	B. WING			C 11/20/2015		
NAME OF PI	ROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP CODE	•		
THE REH/	AB AND HC CTR AT VILL	AGE GR			I PURDUE DRIVE TTEVILLE, NC 28304			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 425	leaving multiple mess nursing (DON) and the reset the ADS because to view the inventory. called the provider of aware of offline concerned ADS crashed. The phe replacement ADS that 11/7/15 but the facility services in the intering In an interview on 11, stated there had been ADS and she had to machine but it was re November and she the The DON stated once the orders were faxed and when the resider paper prescription it we pharmacy tote to be of The DON verified the medications to the fac- cut off time to get me was 5:00 PM. She also backup pharmacy in the was needed prior to the medication at midnight In an interview on 11/1 acknowledged her sig Control Drug Record resident on 11/17/15. night shift and was all received the medication Nurse #8 stated she past " few months "	y calling the facility and sages for the director of he unit manager (UM) to se the pharmacy was unable . She stated the pharmacy the ADS and made them erns on 11/4/15 but then the harmacy ordered a at arrived at the facility on y did have backup pharmacy n. /18/15 at 2:45 PM, the DON n problems recently with the repeatedly reset the eplaced the first part of hought it was working better. e an admission was verified, d to the facility pharmacy it arrived with the original would be placed in the delivered to the pharmacy. e pharmacy delivered cility around midnight and dications the same night so stated the facility utilized a the event that a medication he arrival of the ordered	F	425				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION			X3) DATE COMP	SURVEY LETED
		345380	B. WING _					C 20/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS	S, CITY, STATE, ZIP CODE	· · ·		
THE REH	AB AND HC CTR AT VILL	AGE GR		1601 PURDUE DR FAYETTEVILLE,				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				E	(X5) COMPLETION DATE
F 425	assistant (PA) made the nurses don ' t aler narcotic, she may run stated when the punc area, it was time to ge order not to run out. In a telephone intervit the long term care un to the facility on Satur stated staff normally a narcotic refill and put week before he come medication during we prescription at his offi pharmacy. He stated with resident ' s gettir In an interview on 11/ rehabilitation unit PA ADS that should only and if staff notified hir narcotic medications punch card, there sho refill. The PA stated h minimum 2-3 times w could email the pharm made aware of a nee In a telephone intervit the pharmacy technic internet based but it of the whether or not it w acknowledged the ph refill the ADS unless i technician she was at reset the machine but aware of crashed all the	rounds on the day shift but if t him that they are low on a o ut on night shift. She h card got into the blue et a new prescription in ew on 11/19/15 at 9:48 AM, it physician stated he came rdays and Sundays. He anticipate a need for a the order in his box the es. If a resident needed a ek, he could write ce and fax it to the he had never had any issue og their narcotics as ordered 19/15 at 10:25 AM, the stated the facility had an be used in emergencies n timely when a resident 's were in the blue area on the buld be ample time to get a e was at the facility at eekly and verified that he nacy prescriptions if he was d. ew on 11/19/15 at 11:08 AM, ian stated the ADS was could be accessed at facility	F4	25				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 04/20/2017 1 APPROVED 2: 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345380	B. WING		-	(11/:	; 20/2015
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
THE REH/	AB AND HC CTR AT VILL	AGE GR		601 PURDUE DRIVE	04		
(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 TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 425	was borrowing narcot not review the Contro checked that medicat medications during he In a telephone intervie the pharmacy nurse of monthly facility visit, s medication carts for e stated she was unawa having any narcotic b made aware until yes replaced earlier this n consultant stated she responsible for the re Records to ensure the narcotic borrowing. S reviewed the Control but if she noted any p addressed in her mor facility. A review of the Medic Report dated 8/21/15 completed by the pha the pharmacy technic review of the Control In an observation on was attempting to retr supplemental potassi ADS. The UM attemp never would open to a from the ADS. After th and got the consultant	tics but she normally does of Drug Records but rather ion carts for expired er monthly visits. ew on 11/19/15 at 11:15 AM, consultant stated during her she " spot checks " the expired medications. She are that the facility was orrowing issues and was not terday, the ADS had to be nonth. The pharmacy nurse was uncertain who was view of the Control Drug ere was no evidence of he acknowledged she had Drug Records in the past oroblems, it would have been othly visit report given to the eation Room Compliance , 9/15/15 and 10/28/15 irmacy nurse consultant and cian did not reference a Drug Record sheets. 11/19/15 at 2:45 PM, the UM rieve a onetime dose of um for a resident from the ted three times but the ADS allow retrieve the potassium he third attempt, she went it pharmacist who was in the . The pharmacist was asked	F 425				

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	-	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	·	
THE REH	AB AND HC CTR AT VILL	AGE GR			1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 425	In an interview on 11/ stated the pharmacist and she was unsure of malfunction earlier wi expectation of the DC narcotic medications rather utilize the back	19/15 at 4:50 PM, the DON t was no longer at the facility of the outcome of the ADS tnessed. It was the DN that the facility not borrow under any circumstance but up pharmacy or the ADS.	F	425			
	Ordering and Receivi Pharmacy-Emergence Emergency Kits " (da 2015) included a sect Medications are not b residents. " The order either from the emerge	y Pharmacy Services and ated as effective June 9, ion titled, Procedures: E. " orrowed from other red medication is obtained ency box or automated DS), from the provider up pharmacy that is					
	5/7/15. A review of th record revealed medi following: Xanax 0.25	Imitted to the facility on ne resident ' s medical cation orders included the mg to be given daily at riginally ordered 5/20/15.					
	Record revealed her	#56 ' s Controlled Drug Klonopin was signed out by " borrowed for (Resident					
	consultant pharmacis that the nurses were stated she primarily d and leaves the medic	18/15 at 2:05 PM, the t stated she was not aware borrowing narcotics. She oes the medication reviews ation carts and ADS issues y technician or the nurse					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/20/2017 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345380	B. WING			(11/2	C 20/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
			1	601 PURDUE DRIVE			
THE REH	AB AND HC CTR AT VILL	AGE GR	I	AYETTEVILLE, NC 28304			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)		(X5) COMPLETION DATE
F 425	Continued From page	57	F 425				
	pharmacist recalled th 11/5/15 and she was days before. When th pharmacy could not s or what is being used limit the staff 's ability the ADS according to recalled the pharmacy leaving multiple mess nursing (DON) and th reset the ADS becaus to view the inventory. called the provider of aware of offline conce ADS crashed. The ph replacement ADS tha 11/7/15 but the facility services in the interim In an interview on 11/ stated there had been ADS and she had to r machine but it was re November and she th The DON stated once the orders were faxed and when the residen paper prescription it v pharmacy tote to be o The DON verified the medications to the fac source of the order means backup pharmacy in the	y calling the facility and ages for the director of e unit manager (UM) to se the pharmacy was unable She stated the pharmacy the ADS and made them erns on 11/4/15 but then the armacy ordered a t arrived at the facility on did have backup pharmacy did have backup pharmacy the ADS at 2:45 PM, the DON or problems recently with the epeatedly reset the placed the first part of ought it was working better. e an admission was verified, t to the facility pharmacy t arrived with the original yould be placed in the lelivered to the pharmacy. pharmacy delivered cility around midnight and dications the same night so stated the facility utilized a he event that a medication the arrival of the ordered					

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	-	ID 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
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE REH	AB AND HC CTR AT VILL	AGE GR			601 PURDUE DRIVE AYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 425	In a telephone intervie Nurse #9 stated she f full time since May 20 worked in long term of everywhere else she a narcotic for one res was against policy. N peers had been doing was the facility practic inability to access the never been added to In a telephone intervie the long term care un to the facility on Satur stated staff normally a narcotic refill and put week before he come medication during we prescription at his offi pharmacy. He stated with resident 's gettin In an interview on 11/ rehabilitation unit phy the facility had an AD in emergencies and if when a resident 's na the blue area on the p ample time to get a re the facility at minimur verified that he could prescriptions if he wa In a telephone intervie the pharmacy technic internet based but it of the whether or not it w	ew on 11/19/15 at 9:25 AM, had worked the night shift 15. She stated she had are for a very long time and had ever worked, borrowing ident for another resident urse #9 stated she and her g it so long, she thought it ce to do so. Nurse #9 stated ADS because she had the data base. ew on 11/19/15 at 9:48 AM, it physician stated he came days and Sundays. He anticipate a need for a the order in his box the s. If a resident needed a ek, he could write ce and fax it to the he had never had any issue ig their narcotics as ordered. 19/15 at 10:25 AM, the sician assistant (PA) stated S that should only be used staff notified him timely arcotic medications were in bunch card, there should be efill. The PA stated he was at in 2-3 times weekly and email the pharmacy s made aware of a need.	F	425			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING				LETED		
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER		•	3	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE REH	AB AND HC CTR AT VILL	AGE GR			1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 425	refill the ADS unless i technician she was all reset the machine but aware of crashed all t technician stated she was borrowing narcot not review the Contro checked that medicat medications during he In a telephone intervit the pharmacy nurse of monthly facility visit, s medication carts for e stated she was unaw having any narcotic b made aware until yes replaced earlier this n consultant stated she responsible for the re Records to ensure the narcotic borrowing. S reviewed the Control but if she noted any p addressed in her mor facility. A review of the Medic Report dated 8/21/15 completed by the pha the pharmacy technic review of the Control In an observation on was attempting to retu supplemental potassi ADS. The UM attemp never would open to a	t was online. The pharmacy t the facility on 10/28/15 and t on 11/5/15, she was made ogether. The pharmacy was not aware the facility ics but she normally does I Drug Records but rather ion carts for expired er monthly visits. ew on 11/19/15 at 11:15 AM, consultant stated during her she " spot checks " the expired medications. She are that the facility was orrowing issues and was not terday, the ADS had to be nonth. The pharmacy nurse was uncertain who was view of the Control Drug ere was no evidence of he acknowledged she had Drug Records in the past problems, it would have been on the trading is a state of the aretion Room Compliance , 9/15/15 and 10/28/15 irmacy nurse consultant and ian did not reference a	F	425			

Facility ID: 943524

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/20/2017 APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345380	B. WING			_		C 20/2015
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE REHA	AB AND HC CTR AT VILL	AGE GR			01 PURDUE DRIVE YETTEVILLE, NC 283	304		
(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 BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 425	facility for assistance. to follow up with the ormalfunction. In an interview on 11/ stated the pharmacist and she was unsure or malfunction earlier wite expectation of the DC narcotic medications or rather utilize the back 8. A review of the faci Ordering and Receiving Pharmacy-Emergency Emergency Kits " (da 2015) included a sect Medications are not b residents. " The orde either from the emerg dispensing system (A pharmacy or a back-u determined by the pro- Resident # 21 was ad 11/5/15. A review of tr record revealed media following: Xanax 0.5m hours as needed for a 11/5/15. A review of Resident F Record revealed her f a nurse and noted as #210) " . In an interview on 11/	t pharmacist who was in the The pharmacist was asked butcome of the ADS 19/15 at 4:50 PM, the DON is was no longer at the facility of the outcome of the ADS thessed. It was the DN that the facility not borrow under any circumstance but up pharmacy or the ADS. lity policy titled " Medication ing from y Pharmacy Services and the as effective June 9, ion titled, Procedures: E. " orrowed from other red medication is obtained ency box or automated DS), from the provider up pharmacy that is ovider pharmacy. Imitted to the facility on the resident ' s medical cation orders included the ing to be given every four anxiety originally ordered #21 ' s Controlled Drug Klonopin was signed out by " borrowed for (Resident 18/15 at 2:05 PM, the	F 43	25				
	consultant pharmacis	t stated she was not aware						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/20/2017 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	-	(X3) DATE COMP	SURVEY LETED
		345380	B. WING				C 20/2015
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
	AB AND HC CTR AT VILL			1601 PURDUE DRIVE			
		AGE GR		FAYETTEVILLE, NC 28	304		
(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 ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 425	Continued From page	9 61	F 42	25			
	stated she primarily d and leaves the medic to either the pharmac consultant.	borrowing narcotics. She oes the medication reviews ation carts and ADS issues y technician or the nurse 18/15 at 2:10 PM, Nurse					
	#10 acknowledged he #21 's Control Drug F Resident #210. She s against the facility pol empty and she had di signed prescription fro	er signature on the Resident Record borrowing Xanax for tated she was aware it was licy but the ADS was mostly fficulty with obtaining a om the physician timely. issue has been going on for					
	pharmacist recalled th 11/5/15 and she was days before. When th pharmacy could not s or what is being used limit the staff 's ability the ADS according to recalled the pharmacy leaving multiple mess nursing (DON) and th reset the ADS becaus to view the inventory. called the provider of aware of offline conce ADS crashed. The ph replacement ADS tha 11/7/15 but the facility services in the interim	y calling the facility and ages for the director of e unit manager (UM) to se the pharmacy was unable She stated the pharmacy the ADS and made them erns on 11/4/15 but then the armacy ordered a t arrived at the facility on y did have backup pharmacy					
		problems recently with the					

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	10. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COI	MPLETED
		345380	B. WING		1	C 1/20/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		1/20/2013
THE REHA	AB AND HC CTR AT VILL	AGE GR		1601 PURDUE DRIVE		
				FAYETTEVILLE, NC 28304		
(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 IE APPROPRIATE	(X5) COMPLETIO DATE
F 425	Continued From page		F 42	25		
		eplaced the first part of				
		nought it was working better. e an admission was verified,				
	the orders were faxed	d to the facility pharmacy				
		nt arrived with the original would be placed in the				
		delivered to the pharmacy.				
	The DON verified the	pharmacy delivered				
		cility around midnight and				
	÷	dications the same night so stated the facility utilized a				
		the event that a medication				
	•	he arrival of the ordered				
	medication at midnig	nt.				
	In a telephone intervi	ew on 11/19/15 at 9:48 AM,				
	the long term care un	it physician stated he came				
	2	rdays and Sundays. He anticipate a need for a				
		the order in his box the				
		es. If a resident needed a				
	medication during we					
	prescription at his off	he had never had any issue				
	-	ng their narcotics as ordered.				
		/19/15 at 10:25 AM, the				
		vsician assistant (PA) stated				
		S that should only be used f staff notified him timely				
	•	arcotic medications were in				
		punch card, there should be				
		efill. The PA stated he was at n 2-3 times weekly and				
	verified that he could					
		is made aware of a need.				
	In a telephone intervi	ew on 11/10/15 at 11:08 AM				
	the pharmacy technic	ew on 11/19/15 at 11:08 AM,				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			
		345380	B. WING				C 20/2015
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE REHA	AB AND HC CTR AT VILL	AGE GR			1601 PURDUE DRIVE		
				F	FAYETTEVILLE, NC 28304		
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 425	the whether or not it w acknowledged the ph refill the ADS unless i technician she was at reset the machine but aware of crashed all t technician stated she was borrowing narcot not review the Contro checked that medicat medications during he In a telephone intervie the pharmacy nurse of monthly facility visit, s medication carts for e stated she was unawa having any narcotic b made aware until yes replaced earlier this n consultant stated she responsible for the re Records to ensure the narcotic borrowing. Si reviewed the Control but if she noted any p addressed in her mor facility. A review of the Medic Report dated 8/21/15 completed by the pha the pharmacy technic review of the Control	ould be accessed at facility vas online. She armacy could not log in to t was online. The pharmacy the facility on 10/28/15 and on 11/5/15, she was made ogether. The pharmacy was not aware the facility ics but she normally does I Drug Records but rather ion carts for expired er monthly visits. ew on 11/19/15 at 11:15 AM, consultant stated during her the "spot checks " the xpired medications. She are that the facility was orrowing issues and was not terday, the ADS had to be nonth. The pharmacy nurse was uncertain who was view of the Control Drug ere was no evidence of he acknowledged she had Drug Records in the past roblems, it would have been the thy visit report given to the ation Room Compliance , 9/15/15 and 10/28/15 rmacy nurse consultant and ian did not reference a Drug Record sheets.	F	425			
		11/19/15 at 2:45 PM, the UM ieve a onetime dose of					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE REH	AB AND HC CTR AT VILL	AGE GR			1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 425	supplemental potassi ADS. The UM attemp never would open to a from the ADS. After th and got the consultant facility for assistance. to follow up with the consultant facility for assistance. to follow up with the consultant facility for assistance. to follow up with the consultant facility for assistance. The an interview on 11/ stated the pharmacist and she was unsure of malfunction earlier with expectation of the DC narcotic medications rather utilize the back 9. A review of the faci Ordering and Receivith Pharmacy-Emergence Emergency Kits " (da 2015) included a sect Medications are not b residents. " The order either from the emerged dispensing system (A pharmacy or a back-up determined by the pro- Resident # 177 was a 6/18/15. A review of the record revealed medi following: Ativan 1 mi three times daily as n originally ordered 10/ A review of Resident Record revealed her	um for a resident from the ted three times but the ADS allow retrieve the potassium he third attempt, she went at pharmacist who was in the . The pharmacist was asked butcome of the ADS (19/15 at 4:50 PM, the DON t was no longer at the facility of the outcome of the ADS thessed. It was the DN that the facility not borrow under any circumstance but sup pharmacy or the ADS. (19/15 pharmacy or the ADS) the outcome of the ADS thessed. It was the DN that the facility not borrow under any circumstance but sup pharmacy or the ADS. (11) policy titled " Medication ing from y Pharmacy Services and ated as effective June 9, tion titled, Procedures: E. " porrowed from other ered medication is obtained pency box or automated .DS), from the provider up pharmacy that is povider pharmacy. (DS), from the facility on he resident ' s medical cation orders included the lligrams (mg) to be given eeded to treat anxiety	F	425			

Facility ID: 943524

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		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 LETED
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
THE REH	AB AND HC CTR AT VILL	AGE GR			601 PURDUE DRIVE AYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 425	#89)".	e 65 /18/15 at 2:05 PM, the	F 4	425			
	consultant pharmacis that the nurses were stated she primarily d and leaves the medic	t stated she was not aware borrowing narcotics. She loes the medication reviews ation carts and ADS issues by technician or the nurse					
	pharmacist recalled th 11/5/15 and she was days before. When the pharmacy could not so or what is being used limit the staff 's ability the ADS according to recalled the pharmac leaving multiple mess nursing (DON) and the reset the ADS becaus to view the inventory. called the provider of aware of offline conce ADS crashed. The phe replacement ADS tha 11/7/15 but the facility services in the interim	t arrived at the facility on y did have backup pharmacy					
	stated there had been ADS and she had to n machine but it was re November and she th The DON stated once the orders were faxed and when the resider	n problems recently with the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE REH	AB AND HC CTR AT VILL	AGE GR			601 PURDUE DRIVE AYETTEVILLE, NC 28304		
(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 425	pharmacy tote to be of The DON verified the medications to the fac cut off time to get medi- was 5:00 PM. She also backup pharmacy in the was needed prior to the medication at midnight In an interview on 11/ stated the nurse in que Resident #177 for Re- employed at the faciliti- interview. In a telephone interview the long term care und to the facility on Satur- stated staff normally a narcotic refill and put week before he come medication during we prescription at his offi- pharmacy. He stated with resident 's gettin In an interview on 11/ rehabilitation unit phy the facility had an AD- in emergencies and if when a resident 's na- the blue area on the p ample time to get a re- the facility at minimum verified that he could prescriptions if he wat In a telephone intervie-	delivered to the pharmacy. pharmacy delivered cility around midnight and dications the same night so stated the facility utilized a the event that a medication the arrival of the ordered nt. 19/15 at 9:00 AM, the DON restions who borrowed from sident #89 was no longer ty and unavailable for ew on 11/19/15 at 9:48 AM, it physician stated he came rdays and Sundays. He anticipate a need for a the order in his box the es. If a resident needed a ek, he could write ce and fax it to the he had never had any issue of their narcotics as ordered. 19/15 at 10:25 AM, the sician assistant (PA) stated S that should only be used i staff notified him timely arcotic medications were in bunch card, there should be efill. The PA stated he was at in 2-3 times weekly and	F	425			

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		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE REH	AB AND HC CTR AT VILL	AGE GR			601 PURDUE DRIVE AYETTEVILLE, NC 28304		
(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 425	the whether or not it w acknowledged the ph refill the ADS unless i technician she was at reset the machine but aware of crashed all t technician stated she was borrowing narcot not review the Contro checked that medicat medications during he In a telephone intervie the pharmacy nurse of monthly facility visit, s medication carts for e stated she was unawa having any narcotic b made aware until yes replaced earlier this n consultant stated she responsible for the re Records to ensure the narcotic borrowing. S reviewed the Control but if she noted any p addressed in her mor facility. A review of the Medic Report dated 8/21/15 completed by the pha the pharmacy technic review of the Control In an observation on was attempting to retr supplemental potassi	vas online. She armacy could not log in to t was online. The pharmacy t the facility on 10/28/15 and t on 11/5/15, she was made ogether. The pharmacy was not aware the facility ics but she normally does I Drug Records but rather ion carts for expired er monthly visits. ew on 11/19/15 at 11:15 AM, consultant stated during her she " spot checks " the expired medications. She are that the facility was orrowing issues and was not terday, the ADS had to be nonth. The pharmacy nurse was uncertain who was view of the Control Drug ere was no evidence of he acknowledged she had Drug Records in the past oroblems, it would have been on the tradition compliance , 9/15/15 and 10/28/15 irmacy nurse consultant and ian did not reference a	F	425			

Facility ID: 943524

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345380	B. WING				C 20/2015
NAME OF PR	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE REHA	B AND HC CTR AT VILL	AGE GR			1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(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 431 SS=E	from the ADS. After the and got the consultane facility for assistance. to follow up with the or malfunction. In an interview on 11/ stated the pharmacist and she was unsure of malfunction earlier wite expectation of the DO narcotic medications of rather utilize the back 483.60(b), (d), (e) DR LABEL/STORE DRUC The facility must empth a licensed pharmacist of records of receipt and controlled drugs in sur- accontrolled drugs in sur- accontrolled drugs is mar- reconciled. Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the e- applicable. In accordance with St facility must store all of locked compartments	allow retrieve the potassium he third attempt, she went t pharmacist who was in the The pharmacist was asked butcome of the ADS 19/15 at 4:50 PM, the DON was no longer at the facility of the outcome of the ADS thessed. It was the DN that the facility not borrow under any circumstance but up pharmacy or the ADS. UG RECORDS, GS & BIOLOGICALS loy or obtain the services of t who establishes a system and disposition of all fficient detail to enable an n; and determines that drug nd that an account of all aintained and periodically to used in the facility must be e with currently accepted s, and include the y and cautionary expiration date when		428			12/18/15

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-					FORM	1 APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	345380	B. WING) 20/2015
ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		20/2010
			1	1601 PURDUE DRIVE		
AB AND HC CTR AT VILL	AGE GR		F	FAYETTEVILLE, NC 28304		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG				(X5) COMPLETION DATE
Continued From page	9 69	F	431			
permanently affixed c controlled drugs listed Comprehensive Drug Control Act of 1976 and abuse, except when t package drug distribut	ompartments for storage of I in Schedule II of the Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the					
by: Based on observation record review, the fact agents and inhalers we medications carts revestorage. Findings incl A review of the policy in the Facility " dated outdated, contaminate medications should be stock and returned to In an observation on a 200 hall 11/19/15 at 4 Cosopt eye drops, All Lumigan eye drops (at dated as filled on 10/2 opened. A review of the receiving all three eyes an interview Nurse #3 was to dated eye drop	ns, staff interviews and ility failed to date ophthalmic when opened on 3 or 4 iewed for medication uded: titled " Medication Storage 1/1/12 read in part the ed or deteriorated e removed immediately from the pharmacy. of the medication cart for :10 PM, Resident #57 had ohagan eye drops and all used to treat glaucoma) 24/15 but undated as when he medication administration esident #57 was currently e drops to treat glaucoma. In 8 stated the facility policy os once opened and it must			 BIOLOGICALS 1) Actions taken for Residents #57, # #46, #5, #7: A. On 11/19/2015, eye drops identifie as not dated upon opening were discarded and new ones requested fro pharmacy. B. On 11/19/2015, inhaler identified a not dated upon opening was discarded and a new one requested from pharma 2) Actions taken for all residents due the potential for being affected: A. On 11/19/2015 and 11/20/2015, th DON, appropriate designee, checked a medication carts for expired or undated open medications. Any found were discarded and replacements requested from pharmacy. B. On/before 12/11/2015 all licensed nursing staff were re-inserviced by SD 	ed m ls lccy. to e ill i	
F	S FOR MEDICARE & I DE DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER AB AND HC CTR AT VILL SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR I Continued From page The facility must prov permanently affixed c controlled drugs listed Comprehensive Drug Control Act of 1976 al abuse, except when t package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on observation record review, the fact agents and inhalers w medications carts rev storage. Findings incl A review of the policy in the Facility " dated outdated, contaminate medications should bustock and returned to In an observation on 200 hall 11/19/15 at 4 Cosopt eye drops, Alg Lumigan eye drops (al dated as filled on 10/2 opened. A review of the receiving all three eye an interview Nurse #3 was to dated eye drop have been an oversig	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345380 ROVIDER OR SUPPLIER AB AND HC CTR AT VILLAGE GR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 69 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	S FOR MEDICARE & MEDICAID SERVICES DF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 345380 B. WING, ROVIDER OR SUPPLIER 345380 B. WING, ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFITAGE Continued From page 69 F The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to date ophthalmic agents and inhalers when opened on 3 or 4 medications carts reviewed for medication storage. Findings included: A review of the policy titled " Medication Storage in the Facility" dated 1/1/12 read in part the outdated, contaminated or deteriorated medications should be removed immediately from stock and returned to the pharmacy. In an observation on of the medication cart for 2200 hall 11/19/15 at 4:10 PM, Resident #57 had Cosopt eye drops, Alphagan eye drops and Lumigan eye drops (all used to treat glaucoma) dated as filled on 10/24/15 but undated as when opened. A review of the medication administration record verified that Resident #57 was currently receiving all three eye drops noce	S FOR MEDICARE & MEDICAID SERVICES SEDEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLI A BUILDING. 345380 B. WING	S FOR MEDICARE & MEDICAID SERVICES 0° DEPENDENCIES (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING 345380 B. WING STREET ADDRESS, CITY, STATE, ZP CODE 1601 PURDUE DRIVE FAYETTEVILLE, NC 28304 STREET ADDRESS, CITY, STATE, ZP CODE 1601 PURDUE DRIVE FAYETTEVILLE, NC 28304 SUMMARY STATEMENT OF DEFICIENCIES (EXCALDEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) Continued From page 69 F 431 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Comtrol Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. F 431: 483.60(b)(d)(e) DRUG RECORDS, LABEL/STORE DRUGS A BIOLOGICALS 1) Actons taken for Resident #57, fa storage. Findings included: No 11/19/2015, eve drops identifie as not dated upon opening was discarded and new ones requested fro pharmacy. 1. A not berevation on of the medication cart for 200 hall 11/19/15 at 410 PM, Resident #57 had Cosopt eve drops. Alphagan eve drops and Lumigan eve drops (all used to treat glaucoma) dated as filled on 1024/15 but undated as when opened. A review of the medication admitistration record verified that Resident #57 ws ex currently receiving all three eve drops to treat glaucoma. In an observation on of the Resident #57 ' s eve B. On/before 12/11/2015, inhaler identified a	MENT OF HEALTH AND HUMAN SERVICES OMB NC SFOR MEDICARE & MEDICALD SERVICES OMB NC SFOR MEDICARE & MEDICALD SERVICES OMB NC STREET ADDRESS. CITY. STREET, ADDR

Facility ID: 943524

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
					С	
		345380	B. WING		1	1/20/2015
NAME OF P	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP		DE	
	AB AND HC CTR AT VILI	ACE CR	1601 PURDUE DRIVE			
				FAYETTEVILLE, NC 28304		
(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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 431	Continued From page	e 70	F 43	31		
				Facility that requires outdate	ed,	
	In an observation of t	he medication cart for 300		contaminated or deteriorated		
	long hall 11/19/15 at	4:15 PM, Resident #1 had		to be removed immediately	from stock	
		dated as filled 9/18 and		and returned to pharmacy of		
	Timolol eye drops(bo	oth used to treat glaucoma)		with replacements requested	d from	
		5 but both were undated		pharmacy.		
	when opened. A revie			(2) Dating of applicable me		
		verified that Resident #1		when opened including but r		
	was currently receiving			□ inhalers, insulin pens, eye		
		terview Nurse #4 stated the		(3) The process for commu	-	
	facility policy was to o	• •		unresolved issues or concer included in the above refere		
		started working at the facility #4 was unsure when the		and emphasized in the facili		
		ned but verified she could		programming.	ly one filation	
	have sent undated ey			(4) Any nursing personnel i	not in	
	pharmacy and reorde	-		attendance will be contacted		
		·····		or appropriate designee, and		
	In another observatio	on of the medication cart for		information prior to the empl	•	
	300 long hall 11/19/1	5 at 4:15 PM, Resident #46		scheduled shift.		
	had an Albuterol inha	ler used to treat chronic		3) Actions taken to preven	t further	
	obstructive pulmonar	y disease (COPD) dated as		recurrence:		
	filled 9/28/15 but und	ated when opened. A review		A. DON, or designee, will a	audit	
		ord verified Resident #46		medication carts 2X week for		
	-	ng Albuterol. In an interview		presence of applicable unda	•	
		the facility policy was to		medications, expired medica		
		opened but she only started		discharged residents medica		
		one week ago so she was dication were opened. Nurse		B. Checking med carts on		
		have sent undated inhaler		on-going basis has been as weekend nursing supervisor		
	back to the pharmacy			C. Following Step 3A, DOI		
	replacement.			will conduct random monthly		
				months, followed by quarter		
	In another observation	n of the medication cart for		quarters, and as needed for	•	
		5 at 4:15 PM, Resident #5		with dating opened medicati		
	-	thalmic ointment used to		removing undated opened, e		
	-	ted as filled 9/1/15 but		discharged residents medica		
		d. A review of the medication		the cart. Any non-compliand		
	record verified Reside			addressed by the DON, des		
	receiving the eve eint	tment. In an interview Nurse		soon as practical.		

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	DF DEFICIENCIES					TE SURVEY MPLETED
		345380	B. WING		C 11/20/2015	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	AB AND HC CTR AT VILL	AGE GR		1601 PURDUE DRIVE		
				FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 431		policy was to dated eye	F 43	4) Monitoring for outcomes of	at of	
	working at the facility unsure when the med	ed but she only started one week ago so she was dication were opened. Nurse have sent undated AK-Poly macy and reordered		 established plan and involvement facility QAA/QAPI committee: A. DON, designee, will bring readily audits to morning administrative meeting for review, weekly X 4 veeting 	esults of team	
	replacement. In an observation of t	he medication cart for 300		B. Results of medication cart a be brought to the facility QAA m the DON, designee, and reviewed	audits will eeting by ed by the	
	Symbicort inhaler use filled on 8/15/15 but u review of the medical	4:30 PM, Resident #7 had a ed to treat COPD dated as undated when opened. A tion administration record		QAA committee monthly X 2 mc quarterly X 2 quarters, and as n C. Any non-compliance with e plan will reviewed by the QAA/C	eeded. stablished	
	the inhaler. In an inte the facility policy was	#7 was currently receiving rview with Nurse #5 stated to date inhalers once ave been an oversight.		committee for root cause and interventions implemented as ne and/or established plan revised. D. Discussion, interventions, a	ind/or	
	director of nursing sta	/19/15 at 4:50 PM, the ated it was her expectation edication and inhalers were		revisions to established plan will included in the meeting minutes E. Any adjustment to the established plan, through revision and/or int	olished	
	observed undated an	ened and if any items were d open on the medication rned to the pharmacy and		for non-compliance will require re-inservicing of the applicable s DON, or appropriate designee. F. Any revision to the establish		
F 520	492 75(0)(1) 0 4 4		F 52	will require the monitoring to be at Step 4A and continue as outli	gin again	10/10/15
F 520 SS=E	483.75(0)(1) QAA COMMITTEE-MEMB QUARTERLY/PLANS		F 52			12/18/15
	assurance committee nursing services; a pl	in a quality assessment and consisting of the director of hysician designated by the other members of the				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345380	B. WING				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE REH	EHAB AND HC CTR AT VILLAGE GR				1601 PURDUE DRIVE FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 520	issues with respect to and assurance activit develops and implem action to correct ident A State or the Secret disclosure of the reco except insofar as suc compliance of such co requirements of this s Good faith attempts b and correct quality de a basis for sanctions. This REQUIREMENT by: Based on observation physician interviews, record review, the fac and Assurance Comm to implement a plan o established procedure narcotic medications record review dating b included: This tag is cross refer F425 Based on obser pharmacy staff intervi and record review, the established procedure narcotic medications (Resident #46, #45, #	ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of ified quality deficiencies. ary may not require rds of such committee h disclosure is related to the committee with the ection. y the committee to identify ficiencies will not be used as ' is not met as evidenced ns, staff interviews, pharmacy interviews and ility ' s Quality Assessment nittee (QA Committee) failed f action and monitor follow es for the acquisition of identified on interview and back to July 2015. Findings rred to: vations, staff interviews, e facility failed to follow es for the acquisition of for 9 of 37 residents 121, #33, #160, #270, #56, ing controlled substances.	F	520	 F 520: 483.75(o)(1) QAA COMMITTEI MEMBERS/MEET QUARTERLY/PLAN 1) Action taken for identified area of concern: A. Facility QAA committee will meet on/before 12/16/2015 to discuss the following areas (1) Areas of concern identified during annual survey of 11/16/2015 (2) Actions taken to address areas of concern prior to QAA meeting of 12/16/2015 (3) Effectiveness to date of actions ta and any revisions to adopted plans of correction as needed (4) Methods to: a. Increase staff awareness of QAA committee members, b. Ways for staff to relay areas of 	IS	

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		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 04/20/2017 MAPPROVED D. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345380		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C				
		B. WING			11/20/2015				
NAME OF P	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•			
THE REH	THE REHAB AND HC CTR AT VILLAGE GR			1601 PURDUE DRIVE FAYETTEVILLE, NC 28304					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 520	director of nursing (D acknowledged a prot borrowing narcotics f when the new DON w were unaware of the issue until the survey the QA Committee co medical director, the department leaders.	ON) and administrator olem with the nurses irst identified in July 2015 was hired. Both stated they widespread nature of the r. The administrator stated onsisted of the DON, the pharmacist and other The administrator verified et monthly but had not yet	F	520	concern to QAA committee members, c. Methods for QAA committee to provide responses back to staff regard outcomes of concerns B. All discussion of determined interventions, plans of correction, and revisions to current plans will be include in the QAA meeting minutes. 2) Actions taken for all residents due the potential for being affected: A. All facility staff will be re-inservice on/before 12/18/2015 with regards to: (1) QAA committee members (2) Dates of scheduled QAA committee meetings (3) The process for communicating unresolved issues or concerns will be included in the above referenced inser and emphasized in the facility orientation programming B. The facility QAA committee we meet on a monthly and quarterly basis on ar ongoing basis to address areas of concern brought to the attention of QA committee members. 3) Actions taken to prevent further recurrence: A. The facility QAA committee we review quality measures at a minimum of quarterly for a pro-active approach to identify areas of concern regarding resident care issues and as a committee establish improvement plans and monitoring methods to address areas. B. The process for staff communicating unresolved issues or concerns will be	led to d ee vice on vill n A			

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY		
AND PLAN OF CORRECTION				S	COMPLETED		
		345380	B. WING		C 11/20/2015		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
				1601 PURDUE DRIVE			
THE REH	AB AND HC CTR AT VILI	LAGE GR		FAYETTEVILLE, NC 28304			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CC PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		N SHOULD BE COMPLETIN		
F 520	Continued From page 74		F 52	 included by the SDC, designee, i staff meetings X 3 months, and a needed the facility expectations of following established processes. continue to be emphasized in the orientation programming on an o basis. C. Beginning 12/16/2015, QAA committee will invite, at a minimu direct care staff person to month meetings X 3 months to be follow quarterly X 3 quarters to ascertai comments about effectiveness of committee action plans regarding care. 	Is or Also facility n-going facility facility Im, one y QAA ved by n f QAA		
				 4) Monitoring for outcomes of established plan and involvement facility QAA/QAPI committee: A. During scheduled monthly Q meetings, the facility administrate QA nurse, or appropriate designed bring outcomes of any established improvement for review by the Q committee members for effective an ongoing basis. B. QAA committee member review staff awareness (based on interviction QAA committee awareness and C. QAA committee member review outcomes for trends and any new areas of revision. 	AA or, DON, ee, will ed plan of AA ness on ers will iews) for ourpose. ers will		

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				PRINTED: 04/20/ FORM APPRC OMB NO. 0938-0		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			
	345380	B. WING		C 11/20/2015		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE REHAB AND HC CTR AT VILL	AGE GR		1601 PURDUE DRIVE			
			FAYETTEVILLE, NC 28304			
PREFIX (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 COMPLE		
F 520 Continued From page	e 75	F 52	 D. QAA committee members track improvements and declines in Qua Measures on a minimum of quarter basis, on-going. E. Any revisions made to an established plan by the QAA committee membrequire re-inservicing as needed of applicable staff by the SDC, or appropriate designee. F. Any revisions to any plan established by the QAA committee will require initia a monitoring schedule to be no less monthly X 3 months, followed by of X 3 quarters. G. All discussion of areas of concern, development of interventions, revisioutcomes, revisions, and establish monitoring systems will be include QAA committee meeting minutes. 	ality erly ny bers will of tiation of es than quarterly f ew of nment of		

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