	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	CONTRECTION		A. BUILDIN	IG		C
		345070	B. WING			01/14/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
DURHAM	NURSING & REHABILIT	ATION CENTER		411 S LASALLE STREET DURHAM, NC 27705		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE E APPROPRIATE	COMPLETION
F 241 SS=E	483.10(a)(1) DIGNIT INDIVIDUALITY	Y AND RESPECT OF	F 2	41		2/11/17
	resident in a manner promotes maintenand her quality of life reco individuality. The faci promote the rights of This REQUIREMENT by: Based on observatio interviews, the facility 4 of 8 sampled reside eliminating pests in re (Resident #2, #5, #7 The findings included 1. Resident #2 adm 8/12/15. The quarter dated 11/23/16, indic cognitively intact. During an observation Resident #2 was lying breakfast. There were around the base boars s bed. In addition, the the bed, around the fi compartment storage During an interview of Resident #2 stated the	the resident. T is not met as evidenced ans, resident, staff and family railed to maintain dignity for ents as evidenced by not esident ' s environment. and #8). I: hitted to the facility on y Minimum Data Set (MDS) ated that Resident #2 was n on 1/13/17 at 10:00 AM, g in bed and just received his e live roaches crawling rd underneath the resident ' ere were dead roaches under loor of the side table and in 6 e bins. on 1/13/17 at 10:00 AM, he roaches would crawl on was sleeping. The resident		All residents are treated with respect, Ecolab treated Resi #7 and #8 for pest 1/13/2017 residents' room received a d on 1/31/2017 to include area bed, and behind the furniture All residents could be affected practice therefore all rooms I treated for pest by Ecolab (th exterminator company). The direct caregivers will be by the SDC regarding storag resident's personal belonging reporting evidence of pest to administrator immediately. T will be included in the new en orientation program for direct Ecolab will treat the facility fo 2x weekly for 2 weeks, week twice monthly to ensure com- eliminating pest.	dents #2, #5, 7. The above eep cleaning as beneath the e. ed by this have been he contracted re-educated ge of gs, and the his in-service mployee t care givers. or pest control dy x4, then	
	addition, the resident been going on for sev though the room was	ardian and administration. In reported this problem had veral months and even sprayed, the roaches came tated " It really upsets me		The Administrator, DON, SD Charge Nurses will monitor (observation and resident inter resident/rooms 2x weekly x4	(through direct erview) 10	

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.

02/08/2017

					OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
					С
		345070	B. WING		01/14/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE
	NURSING & REHABILIT	ATION CENTER		411 S LASALLE STREET	
DOILIAN	NORSING & REHABIEN			DURHAM, NC 27705	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 241	Continued From page	e 1	F 24	11	
1 211	continued i com pag		F 24		acroafter until
	that I have to sleep w			weekly x4, then monthly th compliance is achieved in	
	2. Resident #7 was	s admitted to the facility on		in the residents environme	
		um Data Set (MDS) dated			
	7/16/16 indicated Re	sident #7 was cognitively		Data results will be analyz	ed and
l I t	intact.			reviewed at the facility mo	
				meeting for 3 months with	
		on 1/13/17 at 10:24 AM,		plan of correction as need	ed
		tching television and stated I up the walls on a weekly			
		eported that some were seen			
		sident #7 further stated that			
		n had been sprayed several			
		ame from other rooms			
	especially from the b				
		red. In addition, Resident #7			
		different needed to be ey come out a lot at night. No			
		leep with roaches or any			
		all around them. The staff			
	just kill them and kee				
	During an interview of	on 1/13/17 at 11:00 AM, the			
		iring her visit she had			
		nes under Resident #2 ' s			
		t table and in the bathroom.			
		lian reported she had spoken			
		d management about the			
		seem to be done. Resident			
	-	e guardian and facility staff			
		awling on him at night and he sleep because of them. The			
	guardian stated when				
	-	ember, they told her the bug			
	-	been out and additional time			
	was needed for the s	solution that was used to			
	-	and resident were upset it			
		y so long to address the			
	was taking the facility problem.	y so long to address the			

Facility ID: 923264

If continuation sheet Page 2 of 22

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE	E SURVEY PLETED
		345070	B. WING				C / 14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	.	
				4	11 S LASALLE STREET		
DURHAM	NURSING & REHABILIT	ATION CENTER		D	OURHAM, NC 27705		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	Continued From page	2	F	241			
		admitted to the facility rly Minimum Data Set (MDS) ed Resident #8 was					
	Resident #8 stated he his room and the bath Resident #8 reported sprayed or the bug pe bugs come out more fed. Resident #8 repor- seen more at night ar turned on. The reside the time you end up s the spray that was be Resident #8 reported been reported to main stated the housekeep swept them up and ke 4. Resident #5 was 2/5/14. The quarterly dated 11/15/16 indica cognition impairment.	admitted to the facility on Minimum Data Set (MDS) Ited Resident #5 had some					
	Resident #5's family seen both dead and li s room on the wall ne and on the floor next member reported the individually with their roaches.	terview on 1/13/17 1:30 PM, member stated she had ive roaches in Resident #5 ' ext to bed, the nightstand to the bed. The family facility sprayed rooms own bug spray to control the n 1/13/17 at 2:54 PM, the					
	Director of Nursing (D	DON) indicated she was oblem with roaches. The					

Facility ID: 923264

If continuation sheet Page 3 of 22

STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345070	B. WING		C 01/14/2017	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER		11 S LASALLE STREET		
				DURHAM, NC 27705		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		
F 241		e 3 he Maintenance Director to rol company to resolve the	F 241			
	problem. The DON a family members had	lso reported residents and reported concerns with the re informed that the pest				
F 253 SS=D	Administrator indicate concerns of any roac pest control company immediately. The Ma spray the identified at the pest control comp Administrator acknow concerns with the roa any reported concern residents.	on 1/13/17 at 3:41 PM, the ed the expectation when hes or bugs are noted, the y should be contacted intenance Director should reas with local product until bany arrives. The yledged resident and family aches but was unaware of as of roaches crawling on KEEPING & MAINTENANCE	F 253		2/10/17	
	necessary to maintain comfortable interior; This REQUIREMENT by: Based on observation facility failed to label residents in five of six 21, 23, 27 and 45). Findings included: A tour of resident hall following observation A. On 01/13/17 at 9 urinal was observed in	and maintenance services in a sanitary, orderly, and T is not met as evidenced on and staff interviews, the personal care equipment for a sampled rooms (Rooms 7, ls in the facility yielded the s: 0:00 a.m., one unlabeled in the bathroom of Room 21. with four residents shared		Bath basin, urinals and bedpans that were found in rooms #7,#21,#23,#27 a #45 were immediately discarded. New urinals, bath basins and bedpans were replaced and labeled. All residents have the potential to be affected: Resident room audit was conducted by the DON/Charge Nurse to identify othe rooms where urinals, bath basins, or bu	, r	

Facility ID: 923264

If continuation sheet Page 4 of 22

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/27/2017 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345070	B. WING				C / 14/2017
NAME OF P	ROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER			11 S LASALLE STREET URHAM, NC 27705		
(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) COMPLETION DATE
F 253	 B. On 01/13/17 at 4 an emesis basin lying bathroom floor of Roc unlabeled. An unlabe unlabeled urine collect were also present. Ty residents shared the C. On 01/13/17 at 4 collection devices new on the bathroom floor urinal and unlabeled floor. Two resident ro shared the bathroom. D. On 01/13/17 at 5 washbasins with a ur placed inside one of 1 the bathroom floor of items were labeled. T residents shared the E. On 01/13/17 at 5 washbasins were obs toilet tank in the bathroom. In an interview on 01/ #8 stated that the resident floor. The nurse tossed bin. In an interview on 01/ Aide #2 stated that the items and not store the In an interview on the 	 241 p.m., one bedpan with g in it was observed on the om 27. Both items were led washbasin and an ction device for the toilet wo resident rooms with four bathroom. 245 p.m., two unlabeled urine sted together were observed r of Room 23. An unlabeled bedpan were also on the oms with four residents 200 p.m., two stacked inal and emesis basin the basins were observed on Room 45. None of the four two resident rooms with four bathroom. 215 p.m., five unlabeled served stacked on top of the room of Room 7. One basin on and five plastic bottle boms and five residents 213/17 at 5:00 p.m., Nurse ident items in Room 23 d not stored on the bathroom ed all the items in a trash 213/17 at 5:10 p.m., Nurse interfacility policy is to label all nem on the floor. a morning of 01/14/17, the dicated that all staff are 	F	253	pans were improperly labeled or stor Items identified through this process immediately discarded and replaced. The DON or SDC will re-educate the CNA's regarding proper labeling and storage of resident's bath basins, uriu and bedpans. The in-service will be included in the new employee orienta program for direct care giver. The DON/SDC and Department Managers will conduct room rounds of rooms daily x4 weeks then weekly x4weeks and monthly x3 to ensure appropriate storage of personal items Data results will be analyzed and reviewed at the facility monthly QAPI meeting.	were nals ation on 10 s.	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/27/201 FORM APPROVED OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345070	B. WING		C 01/14/2017
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-
DURHAM	NURSING & REHABILIT	ATION CENTER		11 S LASALLE STREET DURHAM, NC 27705	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 253 F 281 SS=D	personal care equipm the floor. When asked available for review, a cleaning and storing of was not provided.	ed her expectation that nent is labeled and stored off d if a facility policy was an explicit policy on the of personal care equipment ICES PROVIDED MEET	F 253 F 281		2/10/17
	as outlined by the cor must- (i) Meet professional This REQUIREMENT by: Based on record revi facility failed to gener	d or arranged by the facility, mprehensive care plan, standards of quality. is not met as evidenced iew and staff interviews, the ate a written physician order		Resident #3 no longer resides in facility.	the
	receipt of a telephone sampled resident (Re Findings included: Two facility policies w policy on " Physician Verbal/Telephone Ord record of each teleph name of the physician time of the order, con of person receiving th policy on " Medicatio stated that " verbal o immediately in the res receiving the order signed by the prescril	rere reviewed. The undated Countersignatures of ders " stated that " The one order shall include the n giving the orderdate and tent of the order, and name he order. " The undated n and Treatment Orders " rders must be recorded sident ' s chart by the person Verbal orders must be per at his or her next visit. " hitted 08/24/16. Diagnoses		All residents have the potential to affected by this practice. A one time audit will be performed DON, SDC and Unit Supervisor of residents' treatment administration (TAR)to ensure that corresponding physician orders are present. Any discrepancies identified through th process will receive MD notification physician order clarification written The DON or SDC will re-educate to licensed nurses on the policy and procedure on obtaining physician Verbal/Telephone orders with an emphasis on documenting on the physician telephone order sheet	d by n current n record g nis on with a n

Facility ID: 923264

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	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	ECONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
CORRECTION	DENTIFICATION NUMBER:	A. BUILDING		COMPLETED
				С
	345070			01/14/2017
ROVIDER OR SUPPLIER				
NURSING & REHABILIT	ATION CENTER			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	ULD BE COMPLETIO
Continued From page	a 6	F 281		
(cerebrovascular acci non-dominant left side weakness. A Brief Int score of 0, indicating impairment, was reco Minimum Data Set (M dated 12/20/16 indica 1 or higher pressure of The Treatment Admin November 2016 and the following order: " normal saline, apply 2 MWF [every Monday, and PRN [as needed dressing. " The Start and Stop Date was 12 No corresponding wri order was present in time of the survey. The printout of the signed Orders as of 29-Nov- In an interview 01/14/ reviewed the online T designated as a telep the name of Nurse #8 In a phone interview 0 #12 indicated that she order over the phone 11/24/16. The Directo the room and the call phone. She stated that on a physician order for into the computer.	ident) affecting e and generalized muscle erview of Mental Status severe cognitive orded on the admission ADS). The quarterly MDS ated the presence of a Stage ulcer. histration Record (TAR) for December 2016 contained Cleanse left buttock with Xeroform and dry dressing Q , Wednesday and Friday] for] soiled/dislodged Date was listed as 11/14/16 2/29/16. itten and signed physician the medical record at the ne order was not present in a Physician Orders " Current 2016 5:14 PM. " /17 at 10:45 a.m., Nurse #1 AR and said the order was obone order. She provided 8 who entered the order. 01/14/17 at 3:30 p.m., Nurse e remembered receiving this from the physician on or of Nursing was present in was placed on speaker at she did not write the order form but entered it directly	F 281	This inservice will be included in t employee orientation program for nurses. The DON, SDC, Medical Records Charge Nurse will audit 5 resident treatment administration records of physician's order 2x weekly for 4 of then monthly x3 months to ensure accuracy in entering of verbal/tele orders. Data results will be analyzed and reviewed at the facility's monthly 0	licensed or ss vith weeks phone
	Continued From page (cerebrovascular acc non-dominant left sid weakness. A Brief Int score of 0, indicating impairment, was reco Minimum Data Set (M dated 12/20/16 indica 1 or higher pressure The Treatment Admir November 2016 and the following order: " normal saline, apply 2 MWF [every Monday and PRN [as needed dressing. " The Start and Stop Date was 1 No corresponding wr order was present in time of the survey. Th printout of the signed Orders as of 29-Nov- In an interview 01/14, reviewed the online T designated as a telep the name of Nurse #8 In a phone interview #12 indicated that sh- order over the phone 11/24/16. The Director the room and the call phone. She stated th- on a physician order into the computer.	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345070 ROVIDER OR SUPPLIER NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 (cerebrovascular accident) affecting non-dominant left side and generalized muscle weakness. A Brief Interview of Mental Status score of 0, indicating severe cognitive impairment, was recorded on the admission Minimum Data Set (MDS). The quarterly MDS dated 12/20/16 indicated the presence of a Stage 1 or higher pressure ulcer. The Treatment Administration Record (TAR) for November 2016 and December 2016 contained the following order: "Cleanse left buttock with normal saline, apply Xeroform and dry dressing Q MWF [every Monday, Wednesday and Friday] and PRN [as needed for] soiled/dislodged dressing. " The Start Date was listed as 11/14/16 and Stop Date was 12/29/16. No corresponding written and signed physician order was present in the medical record at the time of the survey. The order was not present in a printout of the signed Physician Orders " Current Orders as of 29-Nov-2016 5:14 PM. " In an interview 01/14/17 at 10:45 a.m., Nurse #1 reviewed the online TAR and said the order was designated as a telephone order. She provided the name of Nurse #8 who entered the order. In a phone interview 01/14/17 at 3:30 p.m., Nurse #12 indicated that she remembered receiving this order over the phone from the physician on 11/24/16. The Director of Nursing was present in the room and the call was placed on speaker phone. She stated that she did not write the order on a physician order form but entered it directly into the computer.	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345070 B. WING ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 6 (carebrovascular accident) affecting non-dominant left side and generalized muscle weakness. A Brief Interview of Mental Status score of 0, indicating severe cognitive impairment, was recorded on the admission Minimum Data Set (MDS). The quarterly MDS dated 12/20/16 indicated the presence of a Stage 1 or higher pressure ulcer. The Treatment Administration Record (TAR) for November 2016 and December 2016 contained the following order: " Cleanse left buttock with normal saline, apply Xeroform and dry dressing Q MWF [every Monday, Wednesday and Friday] and PRN [as needed for] soiled/dislodged dressing. " The Start Date was listed as 11/14/16 and Stop Date was 12/29/16. No corresponding written and signed physician order was present in the medical record at the time of the survey. The order was not present in a printout of the signed Physician Orders " Current Orders as of 29-Nov-2016 5:14 PM." In an interview 01/14/17 at 10:45 a.m., Nurse #1 reviewed the online TAR and said the order was designated as a telephone order. She provided the name of Nurse #8 who entered the order. In a phone interview 01/14/17 at 3:30 p.m., Nurse #12 indicated that she remembered receiving this order over the phone from the physician on 11/24/16. The Director of Nursing was present in the room and the call was placed on speaker phone. She stated that she did not write the order on a physician order form but entered it directly	SPECIENCIES CORRECTION (X1) PROVIDERSUPPLIER IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE NURSING & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, 2IP CODE SUMMARY STREEMENT OF DEFICENCIES (EACH DERICENCY MUST BE PRECEDED BY FULL (EACH DERICENCY ON LIST BE PRECEDED BY FULL (EACH DERICENCY ON LIST BE PRECEDED BY FULL (EACH DERICENCE) DENTIFYING INFORMATION) PREFIX PREFIX Continued From page 6 (cerebrovascular accident) affecting non-dominant left side and generalized muscle weakness. A Brief Interview of Mental Status score of 0, indicating severe cognitive impairment, was recorded on the admission Minimum Data Set (MDS). The quarterly MDS dated 12/20/16 indicated the presence of a Stage 1 or higher pressure ulcer. F 281 The Treatment Administration Record (TAR) for November 2016 and December 2016 contained the following order: " Cleanse left buttock with normal saline, apply Xeroform and dry dressing 0 MWF [every Monday, Wednesday and Friday] and PRN [as needed fof solied/disodged dressing." The Start Date was listed as 11/14/16 and Stop Date was 12/29/16. Data results will be analyzed and reviewed at the facility's monthly C meeting x3 months with a subseq plan of correction as needed. Orders as of 29-Nov-2016 5:14 PM." In an interview 011/41/17 at 10:45 a.m., Nurse #1 reviewed the online TAR and said the order was designated as a telephone order. She provided the name of Nurse #0 who entered the order. In a phone interview 011/41/17 at 10:45 a.m., Nurse #1 reviewed the colline TAR and said the order was designated has a telephone order. She provided the name of Nurse #0 who entered the order. In a ph

Facility ID: 923264

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345070	B. WING		C 01/14/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
DURHAM	NURSING & REHABILIT	ATION CENTER		11 S LASALLE STREET JURHAM, NC 27705	
(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 COMPLETION
F 281 F 469 SS=E	the correct procedure received the order to form, enter it in the co would verify from the been entered correct! In an interview on 01/ Director of Nursing co telephone order she a 11/24/16 was not writt was no written order for th 483.90(h)(4) MAINTA CONTROL PROGRA (h)(4) Maintain an eff so that the facility is fi This REQUIREMENT by: Based on observation family interviews and failed to maintain a pe 8 sampled residents of in 1 of 2 dining rooms Findings included: Resident #2 admitted The quarterly Minimu 11/23/16, indicated th cognitively intact. During an observation Resident #2 was lying breakfast. There were around the base boar s bed. In addition, the	ephone order was received, a was for the nurse who write it on a physician order omputer and a second nurse written order that it had y. (14/17 at 4:00 p.m., the onfirmed that the physician and Nurse #12 received on ten down at the time. There for the physician to sign and the second nurse to verify. UNS EFFECTIVE PEST .M ective pest control program ree of pests and rodents. T is not met as evidenced ns, residents, staff and record review, the facility est free environment for 4 of (Resident #2 #5 #7 and #8) and 2 of 2 shower rooms. I to the facility on 8/12/15. m Data Set (MDS) dated that Resident #2 was in on 1/13/17 at 10:00 AM, g in bed and just received his e live roaches crawling rd underneath the resident ' ere were dead roaches under loor of the side table and in 6	F 281	The facility must maintain an effective pest control program. Resident #2,#5 and #8, dining room and shower room were sprayed for pest on 1/13/2017. All residents could be affected by this practice therefore all rooms have bee treated for pest by Ecolab (the contra- exterminator company). The direct caregivers will be re-educa by the SDC regarding storage of resident's personal belongings, and reporting evidence of pest to the administrator immediately. This in-ser will be included in the new employee orientation program for direct care give	i,#7 ns n cted ted

Event ID: D29E11

Facility ID: 923264

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TATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY PLETED
		345070			C 01/14/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	/14/2017
DURHAM	NURSING & REHABILIT	ATION CENTER		411 S LASALLE STREET DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 469	Resident #2 stated th him at night while he stated he had reporte maintenance, his gua addition, the resident been going on for sev though the room was out even more and st that I have to sleep w Resident #7 was adm 12/10/15. The Minimu 7/16/16 indicated Res intact. During an observation there were small road the walls and on the of There were also dead floor around the back bathroom. During an interview o Resident #7 was wate that roaches crawled basis. Resident #7 re a few nights ago. Res even though the room times, the roaches ca especially from the ba bathrooms were shar stated " Something of sprayed because the one should have to sl other bugs crawling a just kill them and kee	n 1/13/17 at 10:00 AM, e roaches would crawl on was sleeping. The resident ed this concern to indian and administration. In reported this problem had veral months and even sprayed, the roaches came ated " It really upsets me ith roaches. " hitted to the facility on um Data Set (MDS) dated sident #7 was cognitively n on 1/13/17 at 10: 24 AM, ches crawling along side of counter top in the bedroom. d roaches observed on the of the toilet in the n 1/13/17 at 10:24 AM, ching television and stated up the walls on a weekly ported that some were seen sident #7 further stated that n had been sprayed several ume from other rooms athroom since the ed. In addition, Resident #7 lifferent needed to be y come out a lot at night. No leep with roaches or any ull around them. The staff	F 469	 Ecolab will treat the facility for perazx weekly for 2 weeks, weekly x4 twice monthly to ensure compliant eliminating pest. The Administrator, DON, SDC, ar Charge Nurses will monitor (throut observation and resident interview resident/rooms 2x weekly x4 wee weekly x4, then monthly thereafter compliance is achieved in eliminatin the residents environment. Data results will be analyzed and reviewed at the facility monthly Q meeting for 3 months with subsect plan of correction as needed 	, then ce with nd ugh direct w) 10 ks, er until ting pest	

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345070	B. WING				U /14/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
DURHAM	NURSING & REHABILIT	ATION CENTER			411 S LASALLE STREET DURHAM, NC 27705		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 469	The quarterly Minimu 1/7/17, indicated Res intact. During an interview o Resident #8 stated he his room and the bath Resident #8 reported sprayed or the bug pe bugs come out more fed. Resident #8 reported seen more at night ar turned on. The reside the time you end up s the spray that was be Resident #8 reported been reported to main stated the housekeep swept them up and ke During an observation roaches were observe around the base boar The roaches could be door area which was not coming from the k amount of food left or the dining room. Seve chairs had were noted the breakfast meal. During an interview o housekeeper (HK#1) observed in resident of shower rooms. HK#1 roaches, ants etc. we to the maintenance di observations of roach	m Data Set (MDS) dated ident #8 was cognitively in 1/13/17 at 10:24 AM, a had seen some roaches in proom in the past few days. even when maintenance exple sprayed it made them as though they were being ported the roaches could be ad when the lights were ent further added most of the ping on them because ing used wasn ' t working. the roach problem had netenance and other staff and ing department came in and ept going. In on 1/13/17 at 10:30 AM, ed crawling on the walls and d in the main dining room. een seen near the kitchen connected to the dining but kitchen. There was a large in the floor in the corners of eral tables, countertop and d to have leftover food from In 1/13/16 at 10:30 AM, the reported roaches were rooms, dining areas and stated when any bugs, re observed it was reported irector. HK#1 identified ues in Resident #2, #7 and	F	469			
	shower rooms. HK#1 roaches, ants etc. we to the maintenance di observations of roach	stated when any bugs, re observed it was reported irector. HK#1 identified					

Facility ID: 923264

If continuation sheet Page 10 of 22

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/27/2017 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345070	B. WING				C /14/2017
NAME OF PF	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER		41	11 S LASALLE STREET		
				D	URHAM, NC 27705		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 469	dead roaches through the bug people have housekeeping reporte up more dead bugs in Some residents had o but the roaches were During an interview o guardian reported dur observed dead roach bed, behind the night In addition, the guard with maintenance and roaches, but nothing #2 had reported to the that roaches were cra didn ' t want to go to s guardian stated when management in Nove people had already b was needed for the se work. The guardian a was taking the facility problem. During an observation Resident #2 was bein shower stalls. Two of were noted to have ro down the walls and b #1. The Maintenance shower room to confin in the shower area af resident shower.	been an increase of live and nout the facility even though come to spray. Additionally, ed they had been cleaning in the past few months. complained to management still present. n 1/13/17 at 11:00 AM, the ring her visit she had es under Resident #2 ' s table and in the bathroom. ian reported she had spoken d management about the seem to be done. Resident e guardian and facility staff awling on him at night and he sleep because of them. The	F	469			

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	TH AND HUMAN SERVICES				INTED: 02/27/2017 FORM APPROVED IB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME	ED.	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	B. WING			C 01/14/2017
NAME OF PROVIDER OR SUPPL	IER	•	STREET ADDRESS, CITY	, STATE, ZIP CODE	
			411 S LASALLE STREE	T	
DURHAM NURSING & REH	ABILITATION CENTER		DURHAM, NC 27705	5	
PREFIX (EACH DE	IARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY F DRY OR LSC IDENTIFYING INFORMAT		TIX (EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
the bug people previous week roaches starter NAs reported v bugs were see Maintenance I people. Both N was aware of t residents and/v as well. During an obse the Maintenance shower room # confirmed ther walls of the em During an inter Maintenance I roaches prese residents, staff observations o other areas of control person two weeks ago spray the ident local store. The that a call had person a few of would be out to could not come and weather. H were identified observed and I	m page 11 ughout the facility. NA#5 report had come to the facility the and since they had come the d to come out even more. Bo when the roaches or any othe n it was reported to the birector who would contact the As indicated that manageme he roach problem as other or family had reported the pro- ervation on 1/13/17 at 11:45 A ce Director was asked to com 1. The Maintenance Director e were roaches crawling alon pty shower stalls. view on 1/3/17 at 11:45 AM, birector indicated he was awa at within the facility. He report and family had reported f roaches in resident rooms a the facility. He added that the had been in the facility to spr and in between visits he wou ified areas with a product from been placed to the pest contri ays ago and it was told to hin o spray again next Tuesday a e any sooner due to work bac he did the spray with the produc- tion and the spray with the produc- store until the pest control per he Maintenance Director repor- been placed to the pest control per and the spray with the produc- tor until the pest control per he Maintenance Director repor- beat the spray with the produc- store until the pest control per he Maintenance Director repor- beat the spray with the produc- store until the pest control per he Maintenance Director repor- tion and the spray with the produc- store until the pest control per he Maintenance Director repor-	borted bo	469		

Facility ID: 923264

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0938-0391 SURVEY ETED
4/2017
(X5) COMPLETION DATE

Facility ID: 923264

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/27/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED
		345070	B. WING		C 01/14/2017
NAME OF PF	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP COI	•
DURHAM	DURHAM NURSING & REHABILITATION CENTER (x4) ID SUMMARY STATEMENT OF DEFICIENCIES			I S LASALLE STREET JRHAM, NC 27705	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BECOMPLETIONE APPROPRIATEDATE
F 469	Continued From page	2 13	F 469		
	reported she had see resident rooms within HK#3 indicated it was Maintenance Director Director came to the u stuff down and then th HK#3 reported roach November. The bug p building, but the roach even more since they indicated responsibilit dust, clean under bed clean beds and deep week per the cleaning During an interview o Director of Nursing (D aware there was a pre expectation was for th contact the pest contr problem. The DON al family members had u roaches and they wer control company had During an interview o indicated roaches we maintenance and mat	and the Maintenance oom and sprayed some he room was deep cleaned. es had been seen since beople had been in the nes had been coming out had sprayed. HK#3 lies were to sweep, mop, ls, furniture, bathrooms, and clean several rooms per g checklist. In 1/13/17 at 2:54 PM, the DON) indicated she was oblem with roaches. The ne Maintenance Director to ol company to resolve the so reported residents and reported concerns with the re informed that the pest			
	Administrator indicate concerns of any roach pest control company immediately. The Mai	ntenance Director should eas with local product until			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/27/20 FORM APPROVI OMB NO. 0938-03		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345070	B. WING		C 01/14/2017		
NAME OF PI	ROVIDER OR SUPPLIER	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	Y, STATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER		I1 S LASALLE STREET URHAM, NC 27705			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 469	469 Continued From page 14 Administrator acknowledged resident and family concerns with the roaches but was unaware of any reported concerns of roaches crawling on residents.		F 469				
	revealed the family m reported roaches we						
F 490	11/18/16 and 12/28/1 been sprayed for road shower rooms and di recommendations do form. 483.70 EFFECTIVE	control company report dated 6, revealed the facility had ches in resident rooms, ning rooms. There were no cumented on the service	F 490		2/11/17		
SS=E	483.70 Administration A facility must be adm enables it to use its re efficiently to attain or practicable physical, well-being of each re This REQUIREMENT by:	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial		The facility must use its resources			
	interviews, the admin maintain dignity for 4 evidenced by not elin environment. (Reside failed to manage and effectiveness of the p 8 sampled residents	istration, the facility failed to of 8 sampled residents as ninating pests in resident ' s ent #2, #5, #7 and #8). The		effectively and efficiently to attain or maintain the highest practicable physic mental and psychosocial well being. Resident #2, #5,#7 and #8 rooms have been treated to eliminate All residents could be affected by this practice therefore all rooms have been	e		

Event ID: D29E11

Facility ID: 923264

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C		
		345070	B. WING		01/14/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				411 S LASALLE STREET			
DURHAM				DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIO		
F 490 F 514 SS=D	Based on observatii interviews, the facili 4 of 8 sampled resid eliminating pests in (Resident #2, #5, #7 2. This tag was cr Based on observatii interviews and reco maintain a pest free sampled residents (1 of 2 dining rooms 483.70(i)(1)(5) RES	ed: ossed referenced to F241. ons, resident, staff and family ty failed to maintain dignity for dents as evidenced by not resident ' s environment. 7 and #8). ossed referenced to F469. ons, residents, staff and family rd review, the facility failed to e environment for 4 of 8 Resident #2 #5 #7 and #8) in and 2 of 2 shower rooms.	F 490	 treated for pest by Ecolab (the contraexterminator company). Resident belongings will be checked taken out of boxes upon admission to facility. The direct caregivers will be re-educted by the SDC regarding storage of resident's personal belongings, and reporting evidence of pest to the administrator immediately. This in-set will be included in the new employee orientation program for direct care gite Ecolab will treat the facility for pest content for 2 weekly for 2 weekly x4, the twice monthly to ensure compliance eliminating pest. The Administrator, DON, SDC, and Charge Nurses will monitor (through observation and resident interview) for resident/rooms 2x weekly x4 weeks, weekly x4, then monthly thereafter uncompliance is achieved in eliminating in the residents environment. Data results will be analyzed and reviewed at the facility monthly QAPI meeting for 3 months with subseque plan of correction as needed 	and o ated vers. ontrol en with direct 0 ntil g pest		

Facility ID: 923264

If continuation sheet Page 16 of 22

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/27/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345070	B. WING		01/14/2017
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	
DURHAM	DURHAM NURSING & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			411 S LASALLE STREET DURHAM, NC 27705	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 514	standards and practic maintain medical reco are- (i) Complete; (ii) Accurately docum (iii) Readily accessibl (iv) Systematically org (5) The medical recor (i) Sufficient informati (ii) A record of the res (iii) The comprehensi provided; (iv) The results of any and resident review e determinations condu (v) Physician's, nurse professional's progres (vi) Laboratory, radiol services reports as re	h accepted professional bes, the facility must ords on each resident that ented; e; and ganized rd must contain- on to identify the resident; sident's assessments; we plan of care and services of preadmission screening evaluations and acted by the State; t's, and other licensed ss notes; and ogy and other diagnostic equired under §483.50.	F 514	Resident #1 and #3 no longer resid	les in
	interviews, the facility treatment documenta	failed to maintain accurate tion fo two (2) of three (3) th pressure ulcers (Resident		All residents have the potential to be affected by this practice.	

Facility ID: 923264

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/27/201 RM APPROVE O. 0938-039
			. ,	E CONSTRUCTION	· · /	E SURVEY IPLETED C
		345070	B. WING		01/14/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER		411 S LASALLE STREET DURHAM, NC 27705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 514	Continued From page	: 17	F 51	4		
	the diagnoses of left h fibrillation on warfarin ischemic heart diseas renal disease on hem diabetes mellitus. Review of the undated Documentation revea medication administer etc., must be docume records. " Review of the most re 11/15/16, revealed " buttock with NS (norn Xeroform (a petroleur Scheduled 07:00-14:5 order was discontinue treatment administrati Review of the most re 11/16/16 revealed " (0 normal saline, apply S debrider) & cover with Scheduled daily at 9:0 12/04/16. Review of the most re 11/28/16, revealed, " and left and right later Review of the Novem administration record revealed no documen	n dressing) daily ". 59 (7:00 AM-2:59PM). This ed on 12/4/16, per the ion record (TAR). ecent physician order dated Cleanse sacral wound with Santyl ointment (a wound of dry dressing daily. " 00 (AM). Stop date was ecent physician order dated Skin prep bilateral heels ral feet QD (every day).		Therefore a one time audit wa on residents' with pressure uld treatment record for physician accuracy and treatment admin documentation. The physiciar notified and treatment orders we clarified for any discrepancies through this process. The DON and or SDC will re-en- licensed nurses to the policy a procedure for documenting co- treatments as ordered. This in be included in the new employ orientation program for license. The DON, SDC, Medical Reco Charge nurse will audit 5 reside treatment records 2x weekly for then weekly x4 weeks then mo- months to ensure accuracy in documentation. Data results will be analyzed a reviewed at the facility's month meeting x3 months with a sub- plan of correction as needed.	ers order histration n will be identified educate the ind mpletion of hiservice will ree ed nurses. ords or lents or 4 weeks onthly x3 treatment	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/27/2017 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	X2) MULTIPLE CONSTRUCTION (X3		TE SURVEY MPLETED
		345070	B. WING		0,	C 1/14/2017
NAME OF P	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CO	•	
DURHAM	NURSING & REHABILIT	ATION CENTER		11 S LASALLE STREET DURHAM, NC 27705		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 514	Review of the Novem administration record revealed no documer dressing change on t nineteenth (19), twen twenty-seventh (27), (30). Review of the D notes no documentat (2), fifth (5), sixth (6), (9), tenth (10), twelfth fifteenth (15), sixteen eighteenth (18), ninet and twenty-second (2) Review of the Novem administration record revealed no documer bilateral heels and lat twenty-eighth (28), tw (30). Review of the T the month of Decemb the bilateral heels and first, (1), second (2), nineteenth (9) and eight On 1/13/17 at 4:15 P wound care nurse ch there was no wound cart changed the dreat the TAR. On 1/13/17 at 5:21 P wound treatments we nurse. When the wound	care physician noted dated e wound was resolved. her 2016 treatment (TAR) and nursing notes intation of the sacral wound he sixteenth (16), titeth (20), twenty-sixth(26), twenty-ninth(29) and thirtieth becember TAR and nursing ion on the first,(1), second seventh (7), eight (8), ninth n (12), fourteenth (14), th, seventeenth (17), teenth (19), twenty-first (21), 22). her 2016 treatment (TAR) and nursing notes intation of skin prep to teral feet on the venty-ninth (29), and thirtieth tAR and nursing notes for ber revealed no treatment to d feet documented on the third (3), fourth (4), ghteenth (18). M Nurse # 6 indicated the anged the dressings. When care nurse. The nurse on the ssings and documented on M Nurse # 3 indicated ere done by the wound care and care nurse was assigned or was off, then the nurse did the treatment and	F 514			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					NTED: 02/27/2017 FORM APPROVED B NO. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	NG CC		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C 01/14/2017	
		345070	B. WING _						
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	•			
DURHAM	DURHAM NURSING & REHABILITATION CENTER				1 S LASALLE STREET JRHAM, NC 27705				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			<	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
F 514	indicated she provide week unless, she was cart. Then the nurse y administered the trea On 01/14/17 at 9:54 / missing initials indica done or the nurse for On 01/14/17 at 12:49 indicated she was no treatment documenta computer problem. 2. Resident #3 was Diagnoses included r palsy, blindness, hen generalized muscle w A Brief Interview for N of 0, indicating sever recorded on the admi (MDS). The quarterly indicated the presence pressure ulcer. A physician order dat Administration Recor buttock with normal s dry dressing Q MWF and Friday] and PRN soiled/dislodged dres was 12/29/16. No documentation or the TAR for the mont Start Date of the trea month (11/24/16 - 11/	AM Nurse # 2 d and treatment absent on the TAR. She ed the wound care during the s moved to a medication who had Resident #1 tment and documented. AM Nurse # 1 indicated the ted the treatment was not got to document. PM, Director of Nursing t aware of the missing tion. She indicated it was a a admitted 08/24/16. nultiple sclerosis, Bell ' s hiplegia following CVA and veakness. Mental Status (BIMS) score e cognitive impairment, was ission Minimum Data Set MDS dated 12/20/16 ee of a Stage 1 or higher ed 11/24/16 in the Treatment d (TAR) read " Cleanse left aline, apply Xeroform and [every Monday, Wednesday [as needed for] sing. " The Stop Date listed staff initials were present in h of November from the tment through the end of the '30/16). Only two of the 29 or which the order applied	F	514					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 02/27/2013 FORM APPROVED VB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			3) DATE SURVEY COMPLETED C	
		345070	B. WING _				01/14/2017
NAME OF P	ROVIDER OR SUPPLIER	•	_	STR	EET ADDRESS, CITY, STATE, ZIP COI	DE	
DURHAM	URHAM NURSING & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACL DEFICIENCY MUST DE DEFECTED DY FULL				S LASALLE STREET RHAM, NC 27705		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ID PREFIX TAG	(PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 514	On 01/14/17 at 9:50 a acknowledged that w documentation was a indicated that she pro- week unless she was cart. In that case, the care of Residents #1 administering and do In an interview on 01. #1 indicated that miss indicated that the trea nurse forgot to docum she shared was that of was entered by the n time of treatment but on the computer scree On 01/14/17 at 12:49 indicated that she wa treatment documenta #3. She confirmed that the blue laptop comp treatments. 3. The physician or 11/24/16 in the TAR r with normal saline, ap dressing Q MWF [eve and Friday] and PRN soiled/dislodged dress was 12/29/16. The physician order of Wound Care Special Assessment Report a Resident #3 was eva 11/28/16. He noted o Evaluation form the p pressure ulcer on the On an evaluation dat	a.m., Nurse #2 ound and treatment absent on the TAR. She ovided wound care during the assigned to a medication onurse who was assigned and #3 was responsible for cumenting the treatment. /14/17 at 9:54 a.m., Nurse sing initials on the TAR atment was not done or the nent it. Another possibility documentation of treatment urse in the computer at the that it was not showing up the nat the present time. I. p.m. the Director of Nursing as not aware of missing to for Residents #1 and at there was a problem with uter used to record der for Resident #3 dated read " Cleanse left buttock oply Xeroform and dry ery Monday, Wednesday [as needed for] asing. " The Stop Date listed was inconsistent with two ist Evaluations, a Wound and a nursing Progress Note. luated by the physician on in the Wound Care Specialist presence of a Stage 2 eright buttock. ed 12/08/16 the physician ressure ulcer was located on	F 5	514			

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345070	B. WING		C 01/14/20	
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COL	DE	
DURHAM	NURSING & REHABILIT	ATION CENTER		1 S LASALLE STREET JRHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 514	Continued From page	e 21	F 514			
	Wound Treatment Nut the wound location a progress note dated Treatment Nurse door Stage 2. " In an interview 01/13 Treatment Nurse (Nu accompanied the wo rounds. In an interview 01/14 reviewed the docume ulcer location and co present on the right k In an interview 01/14 reviewed the docume ulcer location and sta buttock in the physici transcription error as the computer. In an interview 01/14 stated the physician telephone order. She	/17 at 10:10 a.m., Nurse #1 entation for the pressure ated that the reference to left an order was most likely a the order was entered into /17 at 3:30 p.m., Nurse #12 order was received as a e acknowledged that she may pocation when she entered the				

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