	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
		345325	B. WING		09/19/2019
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	711 \$	EET ADDRESS, CITY, STATE, ZIP CC SUSAN TART ROAD IN, NC 28335	-
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION TE APPROPRIATE DATE
E 000	Initial Comments		E 000		
F 583 SS=D		9.73, Emergency 0XLN11. fidentiality of Records	F 583		10/11/19
		nd Confidentiality. ht to personal privacy and r her personal and medical			
	telephone communica and meetings of famil	dical treatment, written and ations, personal care, visits, y and resident groups, but the facility to provide a			
	right to privacy in his written, and electronic the right to send and mail and other letters materials delivered to	conal privacy, including the or her oral (that is, spoken), c communications, including promptly receive unopened , packages and other the facility for the resident, red through a means other			
	and confidential perso (i) The resident has the of personal and medi- provided at §483.70(i federal or state laws.	sident has a right to secure onal and medical records. ne right to refuse the release cal records except as)(2) or other applicable			

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.

		MEDICAID SERVICES				OMB NO. 0938-03 (X3) DATE SURVEY	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	· /	SURVEY
		345325	B. WING			09	19/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CORNERS	STONE NURSING AND R	REHABILITATION CENTER			11 SUSAN TART ROAD UNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 583	Continued From page	e 1	F 5	583			
	_	ong-Term Care Ombudsman					
		it's medical, social, and					
		ls in accordance with State					
	law.						
		F is not met as evidenced					
	by:	ons, resident and staff			F 583		
		rd review, the facility failed to			F 583		
		catheter bag for 1 of 1			Cornerstone Nursing and Rehabilitatio	n	
	resident. (Resident #				Center acknowledges receipt of the		
		-)			Statement of Deficiencies and propose	es	
	Findings included:				this Plan of Correction to the extent the	at	
					the summary of findings is factually		
	A review of the facility			correct and in order to maintain			
	revealed to assure a	privacy bag was in place.			compliance with applicable rules and	to	
	A review of the medic	cal record revealed Resident			provisions of quality of care of resident The Plan of Correction is submitted as		
	#18 was admitted on			written allegation of compliance.	u		
		iccident, chronic renal			······		
	failure-stage 3, diabe	etes mellitus, hydronephrosis,			Cornerstone Nursing and Rehabilitatio	n	
		neoplasm of urethra, and			Center response to this Statement of		
	retention of urine.				Deficiencies does not denote agreeme		
	A maximum of the energy				with the Statement of Deficiencies nor		
		al minimum data set (MDS) 2/28/2019 revealed the			does it constitute an admission that an deficiency is accurate. Further,	iy	
		gnitively intact and needed			Cornerstone Nursing and Rehabilitatio	n	
		e of one person. Resident			Center reserves the right to refute any		
		air that required one person			the deficiencies on this Statement of		
	to assist for mobility.				Deficiencies through Informal Dispute		
	presence of an indwe	elling urinary catheter.			Resolution, formal appeal procedure		
		sist potos datad 0/40/40			and/or any other administrative or lega	al	
		gist notes dated 6/19/19 18 required the indwelling			proceeding.		
		t urinary retention and			On 9/18/19, the Director of Nursing (D	ON)	
		sues and to maintain comfort			and the Staff Facilitator (SF) initiated a		
	and dryness.				in-service with 100% of all licensed		
					nurses and nursing assistants regardir	ng	
		2/11/2019 revealed Resident			catheter care to include ensuring all	-	
	#18 had an alteration	n in urinary elimination with			catheter drainage bags have a privacy	,	

Facility ID: 923073

If continuation sheet Page 2 of 12

		MEDICAID SERVICES		E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	. ,		COMPLETED	
		345325	B. WING		09/19/2019	
AME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
CORNER	STONE NURSING AND R	EHABILITATION CENTER	;			
(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 SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC	
F 583	Continued From page	e 2	F 583			
	 Continued From page 2 indwelling catheter. Interventions included catheter care per facility protocol, change of the catheter per physician orders, to maintain closed system, observe for signs and symptoms of urinary tract infection. On 9/16/2019 at 3:53pm, Resident #18 was observed sitting in the wheelchair in a public area of the facility. The catheter bag is positioned underneath the wheelchair with no cover on the catheter bag. Urine was visible in the bag. Resident #18 noted the catheter had been 			cover attached. The in-service will completed by 10/11/2019 and prov all newly hired licensed nurses and nursing assistants during orientation the SF.	vided to	
				On 9/19/19, the drainage bag for F #18 was replaced by the treatment with a new drainage bag to include privacy cover.	t nurse ∋ a	
	present for 3- 4 week An observation on 9/ the catheter bag loca	s. 17/2019 at 9:06am revealed ted on the side of the bed ne visible in the bag. At		On 9/19/19, the DON and treatmer completed a 100% audit of all resid include Resident #18 with indwellir catheters to ensure all drainage ba privacy bags. There were no ident concerns during the audit.	dents to ng ags had	
	observed sitting in the of the facility with the	e wheelchair in a public area catheter bag located Ichair with no cover on the		All residents to include Resident # indwelling catheters will be monitor the unit manager and/or the treatm nurse to ensure all catheter draina include a privacy cover weekly for	red by nent ge bags	
	a catheter bag hangin without a cover on th the bag. At 3:09pm, t was noted to be in a the catheter bag under	18/2019 at 9:00am revealed ng on the left side of the bed e bag. Urine was visible in he same day, Resident #18 public area of the facility with erneath the wheelchair with ne is visible in the bag.		weeks, then monthly for 2 months, utilizing the Catheter Care Audit to areas of concern identified during t audit will be addressed immediated unit manager and/ or the treatment to include additional staff training a appropriate. The DON will review a initial the Catheter Care Audit tool	ol. Any the ly by the t nurse as and	
	with the director of nu bags were to be cover covers were available An observation on 9/	19/2019 at 08/:00am bag had no cover on the		The administrator will present the f of the Catheter Care Audit tools to Executive QI committee monthly for months. The QAPI Committee will monthly for 3 months and review th	onths. findings the or 3 meet	

Event ID:0XLN11

Facility ID: 923073

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		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVI D. 0938-03	
TATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		E SURVEY PLETED	
		345325	B. WING				09/19/2019	
NAME OF P	ROVIDER OR SUPPLIER	•	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
CORNER	STONE NURSING AND R	EHABILITATION CENTER			1 SUSAN TART ROAD UNN, NC 28335			
(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 APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE	
F 583		5am, the wound nurse	F	583	trends and/or issues that may need further interventions put into place ar determine the need for further freque of monitoring. The administrator and DON will be responsible for the implementation o corrective actions to include all 100% audits, in services, and monitoring re to the plan of correction.	ency f		
SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that		F 690				10/11/19	
	indwelling catheter or is assessed for remove as possible unless the demonstrates that ca and (iii) A resident who is receives appropriate	ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore						

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	OMB NO. 0938 (X3) DATE SURVEY COMPLETED	
		345325	B. WING		09/19/2019	9
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
			711 SUSAN TART ROAD			
CURNER	TONE NURSING AND R	EHABILITATION CENTER		DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLI TO THE APPROPRIATE DAT	LETION
F 690	Continued From page	e 4	F 6	90		
	continence to the exte					
	§483.25(e)(3) For a r					
	incontinence, based					
		ssment, the facility must t who is incontinent of bowel				
		treatment and services to				
	restore as much norn					
	possible.					
	This REQUIREMENT	is not met as evidenced				
	by:			F 000		
		ons, resident and staff		F 690		
		cal review, the facility broke sures while cleansing an				
		nd failed to apply a leg strap		On 9/18/2019, NA#1 pro	vided correct	
	for 1 of 1 resident rev			catheter care for Reside		
	catheters. (Resident	•		9/19/2019, the Wound N	lurse applied a	
				security anchor to the le		
	Findings included:			excessive tension of the		
		- :		assessed Resident #18	0	
	-	s instructions on care of an even even to a structure to the series of t		infection. No signs of inf by Wound Nurse for Res		
		ith morning care and as		by would huise for Res		
		ent care. Catheter care		On 9/19/219, an audit fo	r 100% of	
		clothes to wash, rinse and		residents with indwelling		
	dry the catheter, hold	ling the catheter at the		include Resident #18 wa	as completed by	
		nsion, and cleaning the		the Wound Nurse to ens	-	
		atus toward the connection		catheters were attached	5	
		bing. The catheter was to be		anchoring device to, pre		
	the catheter.	rap to prevention tension on		tension. There were no f identified at the time of t		
	A rovious of the media	al record revealed Resident		0n0/19/2010 = 1000/ =		
		12/8/2016 with diagnosis of		On 9/18/2019, a 100% a residents with indwelling		
		ccident, malignant neoplasm		to include Resident #18		
		ion of urine, chronic renal		Staff Facilitator (SF) to a	-	
		tes mellitus, hydronephrosis,		cleanliness of catheter to		
	urosepsis.			drainage bags. There we	ere no further	
			1	concerns identified at the		

Facility ID: 923073

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		MEDICAID SERVICES				<u>VO. 0938-03</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		TE SURVEY MPLETED
		345325	B. WING			9/19/2019
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, Z	IP CODE	
CORNERS	STONE NURSING AND R	REHABILITATION CENTER		711 SUSAN TART ROAD DUNN, NC 28335		
(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 CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 690	Continued From page	e 5	F 69	90		
	The care plan dated	2/11/2019 revealed Resident		audit.		
	indwelling catheter. In	nterventions included		On 9/18/2019, NA #1 wa		
		ility protocol, change of the		Staff Facilitator regardin		
		n orders, maintain a closed		security anchoring devic		
	urinary tract infection	for signs and symptoms of		including Resident #18 Foley catheters during of		
				intact. The nurse must b		
	A review of the annua	al minimum data set (MDS)		immediately of any resid		
		2/28/2019 revealed the		indwelling catheter that		
	Resident #18 was co	gnitively intact and needed		missing or unattached s	ecurity anchoring	
		e of one person. The MDS		device that prevents ten		
	-	of an indwelling urinary		catheter tubing. Addition		
	catheter.			in-serviced by Staff Fac		
	A roviow of the urolog	gist notes dated 6/19/19		correct catheter care an techniques to include w		
		18 required the indwelling		tubing from the meatus		
		t urinary retention and			downward.	
		sues and to maintain comfort		On 9/18/2019, the Staff	Facilitator	
	and dryness.			observed NA #1 perform		
	A review of the physic	cian progress notes dated		demonstration of correc	t catheter care	
		Resident #18 had chronic		and proper cleaning tec		
	urinary tract infection	S.		wiping the catheter tubin	-	
				meatus downward. The		
	A review of an emerg	Resident #18 was diagnosed		identified concerns durin demonstration.	ny me retum	
		nfection and was treated				
	with antibiotics.			On 9/18/2019, an in-ser	vice for 100% of	
				all licensed nurses and		
	An interview with Res	sident #18 on 9/17/2019		was initiated by the Dire		
		r kept her from being wet all		(DON) and Staff Facilita		
	the time.			correct catheter care an		
	Obcometion of a st	tor core by NA#4 ar		techniques to include w		
	Observation of cathe	ter care by NA#1 on n revealed the catheter		tubing from the meatus in-service will be comple		
		ed by any device to prevent		10/11/2019. All newly hi		
		er. The catheter tubing was		nurses and nursing assi		
		ipper thigh area. While		in-serviced during orien		
		four inches from the meatus,		regarding correct cathet		

Facility ID: 923073

0 = =		MEDICAID SERVICES				D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	E SURVEY PLETED
		345325	B. WING		09	/19/2019
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
				711 SUSAN TART ROAD		
CORNER	STONE NORSING AND P	REHABILITATION CENTER		DUNN, NC 28335		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 690	Continued From pag	e 6	F 69	00		
		le wipes to clean the		proper cleaning techniques to inc	lude	
		eatus to the point of where		wiping the catheter tubing from the		
		ng held. The NA#1 switched		meatus downward.		
		theter to continue wiping the				
		atheter connected with the		On 9/18/2019, an in-service for 1	00% of	
	tubing. NA #1 washe	d and rinsed the perineal		licensed nurses and nursing assi	stants	
	•	ack strokes. Using the same		was initiated to ensure all resider		
		e catheter four inches from		a security anchoring device attac		
		hed the catheter from the		the indwelling catheter tubing to		
		bing toward the meatus. NA		excessive tension. If the security		
		nd wiped the perineal area,		missing or becomes unattached,		
	then while holding the catheter at the connection of the catheter and tubing, wiped the catheter			nurse must be immediately notific		
	from the meatus to the connection of the catheter			order to replace the security and prevent excessive tension on the		
		ed a towel to dry the catheter		tubing. The in-service will be con		
	-	of the catheter and tubing to		by 10/11/2019. All newly hired lice	-	
		rineal area. An adult brief		nurses and nursing assistants wi		
	-	ied with the catheter tubing		in-serviced during orientation by		
	not secured to a leg			with regards to ensuring all resid		
				an indwelling Foley catheter have		
	An interview with nur	rse aide #1 on 9/18/2019 at		security anchoring device attache	ed to the	
		e of an indwelling catheter		tubing to prevent excessive tensi	on. If the	
		theter care, prevention of		security anchor is missing or bec	omes	
		ter, and to inform the nurse		unattached, the nurse must be		
	ot any issues identified	ed with the catheter or urine.		immediately notified in order to re		
				the security anchor to prevent ex	cessive	
		staff facilitator on 9/18/2019		tension on the catheter tubing.		
	-	staff received in-services		On 9/19/2019, the Director of Nu	reina	
	-	ndwelling catheters and equired starting at the		(DON) and SF initiated a return	ising	
	-	al area and cleaning down		demonstration of correct catheter	care	
		he connection of the catheter		with 100% of all licensed nurses		
		facilitator further noted		nursing assistants. Return demo		
	-	pected to be performed daily		will completed by 10/11/2019. Ar		
		h each incontinent care.		concerns identified during the ret	-	
				demonstration will be addressed		
	An interview conduct	ted on 9/19/2019 at 7:45am		immediately by the DON and SF	to	
	with the director of n	ursing revealed a leg strap or		include additional staff training.		
	device was to be use	ed to secure the tubing of a				

Facility ID: 923073

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ICAID SERVICES			OMB NO. 0938-039
PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
345325	B. WING		09/19/2019
		STREET ADDRESS, CITY, STATE, ZIP CODE	
BILITATION CENTER		711 SUSAN TART ROAD DUNN, NC 28335	
T BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION
vealed in-services for arted for the staff. 19 at 08:00am d no leg strap or device ng. he wound nurse	F 69	 All residents with indwelling cathinclude Resident #18, will be revieweekly for 4 weeks, then monthly months by the unit manager and treatment nurse utilizing a Cather Audit tool to ensure a security and device is attached to the tubing, areas of concern identified durin audit will be immediately address unit manager and/or the treatment to include replacement of the see anchor and attaching the securit to the involved resident □s leg ar additional staff training. The DOI review and initial the Catheter C tools weekly for 4 weeks, then m 2 months to ensure completion. All residents with indwelling cathinclude Resident #18 will be audit the Assistant Director of Nursing and/or unit manager by observing licensed nurses or nursing assis including NA #1 for correct care proper catheter cleaning techniq utilizing the Catheter Care Audit audit will be conducted weekly for weeks, then monthly for 2 monthing. The DON will review and the Catheter Care Audit audit will be conducted weekly for weeks, then monthly for 2 monthing. The DON will review and the Catheter Care Audit tools weeks, then monthly for 2 monthing. The DON will review and the Catheter Care Audit tools weeks, then monthly for 2 monthing. The DON will review and the Catheter Care Audit tools weeks, then monthly for 2 monthing. The DON will review and the Catheter Care Audit tools weeks, then monthly for 2 monthing. The DON will review and the Catheter Care Audit tools weeks, then monthly for 2 monthing. The DON will review and the Catheter Care Audit tools weight tools weeks, then monthly for 2 monthing. The DON will review and the Catheter Care Audit tools weeks, then monthly for 2 monthing. The administrator will present the for the Catheter Care Audit tools weight and to the Catheter Care Audit tools weight tools. 	viewed y for 2 l/ or eter Care nchoring Any g the sed by the ent nurse curity y anchor nd/or N will are Audit nonthly for vieters to lited by (ADON) 10% of tants, including ues tool. The or 4 ns. Any e DON or al staff d initial eekly for 4 ns to e findings to the
	SILITATION CENTER ENT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION) I in the facility. The vealed in-services for arted for the staff. I 9 at 08:00am d no leg strap or device ng. I e wound nurse a leg strap.	A. BUILDING 345325 B. WING	A BUILDING 345325 STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335 D PROVDER'S PLAN OF CORR 713 SUSAN TART ROAD DUNN, NC 28335 INT OF DEFICIENCIES THE PRECEDED BY FULL ENTIFYING INFORMATION) D PREFIX TAG PROVDER'S PLAN OF CORR (EACH CORRECTIVE ACTIONS PLAN OF CORRECTIVE ACTIONS PLAN (EACH CORRECTIVE ACTIONS PLAN OF CORRECTIVE ACTIONS PLAN (EACH CORRECTIVE ACTIONS PLAN OF CORRECTIVE ACTIONS PLAN (EACH CORRECTIVE ACTIONS PLAN OF CORRECTIVE ACTIONS PLAN OF CORRECTIVE ACTIONS (EACH CORRECTIVE ACTIONS PLAN OF CORRECTIVE ACTIONS ACTIONS PLAN OF CORRECTIVE ACTIONS PLAN OF CORRECTIVE ACTION OF C

Event ID:0XLN11

Facility ID: 923073

If continuation sheet Page 8 of 12

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		ATE SURVEY OMPLETED	
		345325	B. WING			09/19/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI			
CORNER	STONE NURSING AND R	REHABILITATION CENTER		711 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE	
F 690 F 761 SS=B	CFR(s): 483.45(g)(h) §483.45(g) Labeling Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h)(1) In accor Federal laws, the face biologicals in locked temperature controls personnel to have acc §483.45(h)(2) The face locked, permanently storage of controlled the Comprehensive I	nd Biologicals (1)(2) of Drugs and Biologicals is used in the facility must be e with currently accepted es, and include the ry and cautionary expiration date when of Drugs and Biologicals ordance with State and ility must store all drugs and compartments under proper , and permit only authorized iccess to the keys. cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to	F 6	 90 The Executive QI Comm monthly for 3 months and Catheter Care Audit tools trends and/or issues that further interventions put determine the need for fu of monitoring. The administrator and Duresponsible for the imple corrective actions to inclu- audits, in services, and ru- to the plan of correction. 	ittee will meet d review the s to determine t may need into place and to urther frequency ON will be mentation of ude all 100%	10/11/19	

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STATELENT OF DEFICIENCIES INDEXAN OF CORRECTION QC1 MELTED IDENTIFICATION NUMBER 345325 QC2 MELTED B WNO QC2 MELTED B WNO QC2 MELTED B WNO QC2 MELTED B WNO MAKE OF PROVIDER OR SUPPLIER CORRECTOR NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 23335 STREET ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 23335 OP 100 (COM DEFICIENCIES ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 23335 OP 100 (COM DEFICIENCIES ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 23335 OP 100 (COM DEFICIENCIES ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 23335 OP 100 (COM DEFICIENCIES ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 23335 OP 100 (COM DEFICIENCIES ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 2335 OP 100 (COM DEFICIENCIES ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 2335 OP 100 (COM DEFICIENCIES ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 2335 OP 100 (COM DEFICIENCIES ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 2335 OP 100 (COM DEFICIENCIES ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 2335 OP 100 (COM DEFICIENCIES ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 2335 OP 100 (COM DEFICIENCIES ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 2335 OP 100 (COM DEFICIENCIES ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 200 (COM DEFICIENCIES COM DEFICIENCIES ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, C 2335 OP 100 (COM DEFICIENCIES COM DEFICIENCIES ADDRESS, CITY, STATE, 2/P CODE T11 SUSAN TART ROAD DUN, COM DEFICIENCIES COM			ND HUMAN SERVICES MEDICAID SERVICES	-			1 APPROVED 0. 0938-0391
INME OF PROVIDER OR SUPPLIER Contraction CORRERTONE NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE TH SUBARY TART ROAD DUNN, NC 23335 STREET ADDRESS, CITY, STATE, ZIP CODE TH SUBARY TART ROAD DUNN, NC 23335 STREET ADDRESS, CITY, STATE, ZIP CODE TH SUBARY TART ROAD DUNN, NC 23335 STREET ADDRESS, CITY, STATE, ZIP CODE TH SUBARY TART ROAD DUNN, NC 23335 STREET ADDRESS, CITY, STATE, ZIP CODE TH SUBARY TART ROAD DUNN, NC 23335 STREET ADDRESS, CITY, STATE, ZIP CODE TH SUBARY TART ROAD DUNN, NC 2335 STREET ADDRESS, CITY, STATE, ZIP CODE TH SUBARY TART ROAD DUNN, NC 2335 STREET ADDRESS, CITY, STATE, ZIP CODE TH SUBARY TART ROAD DUNN, NC 2335 STREET ADDRESS, CITY, STATE, ZIP CODE TH SUBARY TART ROAD DUNN, NC 2335 STREET ADDRESS, CITY, STATE, ZIP CODE TH SUBARY TART ROAD DUNN, NC 2340 STREET ADDRESS, CITY, STATE, ZIP CODE TH SUBARY TART ROAD DUNN, NC 2340 STREET ADDRESS, CITY, STATE, ZIP CODE TH SUBARY TART ROAD DUNN, NC 2340 STREET ADDRESS, CITY, STATE, ZIP CODE TH SUBARY TART ROAD DUNT STREET ADDRESS, CITY, STA				· /			
NAME OF PROVIDER OR SUPPLEX STREET ADDRESS, CITY, STATE_DP CODE CORNERSTONE NURSING AND REHABILITATION CENTER TISUBAN TAR TRADUE IMAID TAG SUMMARY STATEMENT OF DEFICIENCIES (CAN) DEFICIENCIES DE YTILL REGULATORY OR LSC IDENTIFYING INFORMATION) IP F761 Continued From page 9 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not merit as evidenced by: Based on observations, staff interviews and record review the facility failed to remove expired medications from 1 of 1 medication refrigerators. Findings Included: A review of the facility's medication storage policy (revised 11/1/17) revealed no reference to expiration date of 9/13/19. F761 An observation of the refrigerators. Findings resent revealed 2 bottles of Magic Mouthwash with expired dates. Bottle #1 had an expiration date of 9/13/19. F761 An interview was conducted with the Director of Nursing on 09/19/19 at 11:34 AM. She stated the nurses were responsible for checking the expiration date of 9/13/19. F761 An interview was conducted with the Director of Nursing on 09/19/19 at 11:34 AM. She stated the nurses were responsible for the expiration date of 9/13/19. F761 An interview was conducted with the Director of Nursing on 09/19/19 at 11:34 AM. She stated the nurses were responsible for checking the expiration date of 9/13/19. F761 An interview was conducted with the Director of Nursing on 09/19/19 at 11:34 AM. She stated the nurses were responetecting the expired bottles of Magic Mouthweash in the			345325	B. WING		09/1	19/2019
CONNERSTONE NURSING AND REHABILITATION CENTER DUNN, NC 28335 (%1)0 PRETX TAC BUMMARY STATEMENT OF DEFICIENCIES (CALI DEFICIENCIES OF YILL) REGULATION ON LSC DEXTENSING RELATION OF CORRECTION RECORRECTING ACTION SHOULD BE CONSISTENT ACTION SHOULD BE CONSISTENT ACTION SHOULD BE DEFICIENCY) (%9) CONSISTENT CONSISTENT ACTION SHOULD BE CONSISTENT ACTION SHOULD BE DEFICIENCY) (%9) CONSISTENT CONSISTENT ACTION SHOULD BE DEFICIENCY (%9) CONSISTENT CONSISTENT ACTION SHOULD BE DEFICIENCY (%9) CONSISTENT CONSISTENT ACTION SHOULD BE DEFICIENCY (%9) CONSISTENT CONSISTENT ACTION SHOULD BE DEFICIENCY (%9) CONSISTENT ACTION SHOULD BE DEFICIENCY (%9) CONSISTENT CONSISTENT ACTION SHOULD BE DEFICIENCY (%9) CONSISTENT ACTION SHOULD BE DEFICIENCY	NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CC		
DUNN, NC 2833 PRETIX TAG SUMMARY STATEMENT OF DEFICIENCIES INCLUSTION OF LISC DEPUTIENCE IN FULL REGULATORY OF LISC DEPUTIENCE IN FORMATION ID PRETIX TAG ID PRETIX TAG </td <td>CORNERS</td> <td>STONE NURSING AND R</td> <td>EHABILITATION CENTER</td> <td></td> <td></td> <td></td> <td></td>	CORNERS	STONE NURSING AND R	EHABILITATION CENTER				
Import IEACH CORRECT AUST BE PRECIDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PREFIX TAG Cach CORRECT ACTION SHOULD BE CROSS-REFERENCED to THE APPROPRIATE Commettee DEFICENCY F 761 Continued From page 9 package drug distribution systems in which the user readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to remove expired medications from 1 of 1 medication refrigerators. F 761 F indings Included: A review of the facility is medication storage policy (revised 11/1/17) revealed to reference to expired medications in the refrigerators. F 761 A review of the facility is medication storage policy (revised 11/1/17) revealed to reference to expiration date of 9/12/19 and bottle #2 had an expiration date of 9/12/19 and bottle #2 had an expiration date of 9/13/19. F 781 An interview was conducted with the Director of Nursing on 00/19/19 at 11:34 AM. She stated the nurses were responsible for checking the expiration date of 9/13/19. F 100 An interview was conducted with the Director of Nursing on 00/19/19 at 11:34 AM. She stated the nurses were responsible for checking the expiration date of 9/12/19 and bottle #2 had an expiration date of the medications in the refrigerator. Her expectation was the nurses pull the expired medication and dispose of it properly. F 0 Do N observed the 2 expired bottles of Magic Mouthwash in the and immediately removed and					DUNN, NC 28335		
 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 remove expired medications from 1 of 1 medication refrigerators. Findings Included: A review of the facility's medication storage policy (revised 11/1/17) revealed no reference to expired medications in the refrigerators. An observation of the refrigerator in the medication storage room with the Director of Nursing present revealed 2 bottles of Magic Mouthwash with expired dates. Bottle #1 had an expiration date of 9/12/19 and bottle #2 had an expiration date of 9/13/19. An interview was conducted with the Director of Nursing on 09/19/19 at 11:34 AM. She stated the nurses were responsible for checking the expired medication and dispose of it properly. An interviem date on the medications in the refrigerator. Her expectation was the nurses pull the expired medication and dispose of it properly. Con 9/19/19, the DON observed the 2 expired bottles of Magic Mouthwash in the and mission that any doft clicencies on discarded the bottles. The medication frequerator was inspected by the DON and no other expired medication and dispose of it properly. 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	COMPLETION
expired medications were found.	F 761	package drug distribu quantity stored is min be readily detected. This REQUIREMENT by: Based on observatio record review the fac medications from 1 of Findings Included: A review of the facility (revised 11/1/17) reve expired medications if An observation of the medication storage ro Nursing present reve Mouthwash with expi expiration date of 9/1 expiration date of 9/1 An interview was con Nursing on 09/19/19 nurses were respons expiration date on the refrigerator. Her expo	ution systems in which the nimal and a missing dose can T is not met as evidenced ons, staff interviews and ility failed to remove expired f 1 medication refrigerators. y's medication storage policy ealed no reference to in the refrigerators. e refrigerator in the boom with the Director of aled 2 bottles of Magic red dates. Bottle #1 had an 2/19 and bottle #2 had an 3/19. nducted with the Director of at 11:34 AM. She stated the ible for checking the e medications in the ectation was the nurses pull	F 76	1 F 761 Cornerstone Nursing and Recenter acknowledges receip Statement of Deficiencies at this Plan of Correction to the the summary of findings is facorrect and in order to main: compliance with applicable of provisions of quality of care. The Plan of Correction is su written allegation of complia Cornerstone Nursing and Recenter response to this State Deficiencies does not denot with the Statement of Deficiencies does not denot with the Statement of Deficiencies does it constitute an admiss deficiency is accurate. Furth Cornerstone Nursing and Recenter reserves the right to the deficiencies on this State Deficiencies through Informate Resolution, formal appeal privand/or any other administrate proceeding. On 9/19/19, the DON observerses of Magic Moand immediately removed a the bottles. The medication	ehabilitation ot of the nd proposes e extent that actually tain rules and of residents. bmitted as a nce. ehabilitation tement of e agreement encies nor ion that any ner, ehabilitation refute any of ement of al Dispute rocedure tive or legal ved the 2 uthwash in the nd discarded refrigerator	

Event ID: 0XLN11

Facility ID: 923073

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		ND HUMAN SERVICES			FORM APP OMB NO. 093	
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345325	B. WING _		09/19/20)19
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COL	DE	
CORNER	STONE NURSING AND I	REHABILITATION CENTER		711 SUSAN TART ROAD DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COM E APPROPRIATE	(X5) IPLETIO DATE
F 761	Continued From page	ge 10	F7		r 100% of all nd ired dication ation ill be newly hired he in-service regarding discarding e medication ation sing (ADON) monitor the igerator to as are ion date nthly for 2 on Expiration tified during nmediately by anager to ag as al the bol weekly for months. t the findings Audit tool s to monthly for 3 e will meet view the bol to es that may	

Event ID: 0XLN11

Facility ID: 923073

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		ID HUMAN SERVICES					INTED: 10/28/2019 FORM APPROVED
STATEMENT O	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTR			IB NO. 0938-0391) DATE SURVEY COMPLETED
		345325	B. WING _				09/19/2019
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD			F	09/19/2019
					N TART ROAD	-	
CORNERS	TONE NURSING AND R	EHABILITATION CENTER		DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761	Continued From page	≥ 11	F	freque The a respo corre- audits	o determine the need for ency of monitoring. administrator and DON wonsible for the implement active actions to include a s, in services, and monito e plan of correction.	vill be tation of all 100%	
	7(02-99) Previous Versions Obs	solete Event ID: 0X		Facility ID: 92	22073	lf oo stissestis	n sheet Page 12 of 12

Facility ID: 923073

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