APR 14 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING ______ B. WING ______	03/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON REHABILITATION & HEALTHCARE CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to care plan behaviors or interventions to care for the resident exhibiting disrobing behaviors for 1 of 16 sampled residents (Resident # 161) whose care plan was reviewed. Findings include: Resident # 161 was admitted on 10/15/10 with cumulative diagnoses of status post motor vehicle accident with frontal impact and subarachnoid hemorrhage. The resident's primary care physician completed	F 279	**This facility acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.** **Our response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, this facility reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding** F 279—483.20 (k) (1) DEVELOP COMPREHENSIVE CARE PLANS **Compliance Date 4/15/2011** 1. The care plan for Resident # 161 was revised to include noted behaviors. 2. 100% audit of Resident Care plans completed to assure behaviors demonstrated are on	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] / JONATHAN C JAMES
TITLE: ADMINISTRATOR
(X6) DATE: 4-13-2011

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.

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F 279	Continued From page 1 a history and physical on 10/18/10. Under the PHYSICAL EXAM, the physician documented under PSYCHIATRIC, that Resident # 161 had no apparent disorder of mood or affect. He added the resident was alert and oriented to person and significantly less oriented to place and time. Under ASSESSMENT, the physician had written dementia, status post subarachnoid hemorrhage. The presence of behaviors was not mentioned. On 10/21/10 at 7:35 PM, the nurse's notes indicated Resident # 161 was picking at the covers, was anxious and was stripping off his clothing. There was no indication the nurse attempted to engage the resident in diversional activities. The behaviors or interventions to address the behaviors were not added to the care plan. The Admission Minimum Data Set (MDS) for Resident # 161, dated 10/22/10, indicated he had significant cognitive impairment. He was not coded as having signs and symptoms of delirium or behaviors. The resident did not trigger Behavioral Symptoms on the Care Area Assessment Summary, therefore, a care plan for behaviors was not generated. A nurse's note for 10/25/10 at 9:45 PM, indicated Resident # 161 would pick at anything within reach and continued to take off his clothing. There was no documentation intervention or diversion was attempted. The disrobing and/or interventions to assist staff in dealing with the disrobing was not added to the care plan. Nurse's notes dated 11/05/10 at 4:10 PM, indicated Resident # 161 pulled his gown off and pushed the covering back several times. There	F 279	the care plan and appropriate interventions are in place. 3. The MDS Coordinator and the MDS nurse have been retrained on revision of care plans to include behaviors. 4. The Director of Nursing, and the MDS nurse will perform random audits of resident care plans weekly x4, monthly x 3 and then quarterly or as determined by the monthly QI committee based on results of the audits. 5. The results of the audits will be reported to the Quarterly QA Executive Committee and adjustments made as determined to maintain compliance.	

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F 279	Continued From page 2 was no documentation of attempts of diversion. The disrobing was not addressed in the care plan. On 11/10/10, the resident was seen by the physician again for significant agitation. The physician added the resident was frequently seen to be stripping off his clothes. Under PSYCHIATRIC, the physician documented the resident had significant dementia and that Resident # 161 was not agitated at the time of the exam. The plan was to increase the Seroquel to 25 milligrams (mg) twice daily. The resident's agitation or behavior of disrobing was not added to the care plan. There were no interventions to assist the staff in dealing with the disrobing. Progress Notes for the Interdisciplinary Care Plan team from 11/05/10 through 01/07/11 were reviewed. There was no indication the resident had behavioral symptoms. There were no interventions to treat any behavioral symptoms discussed and there was no indication the resident received an antipsychotic medication. Interventions for the behavior of disrobing were not added to the care plan. During the consultant pharmacist DRUG REGIMEN INITIAL REVIEW,dated 11/18/10, the pharmacist questioned the indication for the antipsychotic medication. The resident's care plan with a date of 02/22/11, did not address any behaviors for Resident # 161. The care plan did not address non-pharmaceutical interventions to deal with Resident # 161's disrobing. Physician orders for March 2011 included Seroquel 25 mg per GT twice daily. The order	F 279		

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F 279	Continued From page 3 had a start date of 11/10/10. An observation was made on 09/23/11 at 9:07 AM. Resident # 161 was lying quietly in bed with his eyes open. The resident was "picking" at the sheets. An observation was made of the resident on 03/23/11 at 4:07 PM. The resident was sitting quietly in a geriatric chair. On 03/24/11 at 8:49 AM, Resident # 161 was lying in bed. No behaviors were observed. At 10:15 AM, the resident remained in bed. No behaviors were observed. An interview was held with the Director of Nursing (DON) on 03/24/11 at 2:41 PM. She stated behaviors should be care planned. An interview was held with the MDS Coordinator on 03/24/11 at 4:17 PM. The MDS Coordinator stated issues such as weight loss and pressure ulcers were care planned. The MDS Coordinator stated unless the nurse had documented behaviors during the MDS assessment period she would not care plan behaviors, even if medication were being given.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to follow	F 281		

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F 281	Continued From page 4 physician's orders in flushing a gastrostomy tube after medication administration for 1 of 4 sampled residents (Resident #170) who was observed on medication pass. Findings include: The facility policy, titled GASTROSTOMY TUBE FEEDING - BOLUS, dated 02/2007, indicated under Procedure; Paragraph number 8, that installation of formula or medication should be followed with 30 to 60ccs (cubic centimeters) of water. Resident # 170 was admitted on 12/03/10 with cumulative diagnoses of anoxic encephalopathy, cerebrovascular accident and status post placement of a gastrostomy tube (GT). The resident's care plan, dated 02/14/11, indicated water flushed should be administered per physician's orders. The March 2011 orders for Resident #170 included an entry to flush the resident's GT with 50 ml (milliliters) of water before and after medications were given. Nurse #1 was observed, on 03/23/11 at 9:23 AM, administering Resident # 170's medication via his GT. The nurse checked for patency of the tube prior to administration by instilling approximately 30cc of water into the GT. Nurse #1 then poured Vitamin C into the GT followed by a cup of crushed pills that had been mixed with water. After that, Nurse #1 administered diluted potassium and lastly a protein supplement mixed with water. The nurse did not flush the GT after each medication nor after completion of the protein supplement. The resident's tube feeding was then started.	F 281	F-281- 483.20 (k) (3) (i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS **Compliance Date 4/08/2011** 1. Nurse #1 has been trained regarding the policies and procedures for proper Gastrostomy tube care to include flushes and medication administration. 2. A 100% in-service of licensed nursing staff has been completed regarding the policies and procedures for Gastrostomy tube care including flushes and medication administration. Training will continue bi-annually to assure compliance. 3. The Director of Nursing, the Assistant Director of Nursing and other Administrative nursing staff will perform random audits 2 x weekly for 4 weeks, once weekly for 4 weeks and then monthly x 3 months or as determined by the	

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F 281	Continued From page 5 An interview was held with Nurse #1 on 03/23/11 at 4:18 PM. She stated the policy was to flush the GT before and after medications were given. Nurse #1 stated she had forgotten to flush the GT after completion of her medication administration. An interview was held with the Director of Nursing (DON) on 03/23/11 at 5:42 PM. The DON stated she expected nurses to check for GT patency by flushing with water prior to medication administration and then flush the GT after completion of medication administration. If medications were given separately, the expectation would be to clear the GT after each medication. The DON stated if the protein supplement was the last thing given to Resident # 170, the expectation would be to clear the GT prior to beginning the tube feeding.	F 281	QI committee based on audit results. 4. The results of the audit will be presented to the Quarterly QA committee and adjustments made to the audits as determined to maintain compliance.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		

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F 329	Continued From page 6 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to provide justification for the use of an antipsychotic for 1 of 10 sampled residents (Resident # 161) that was reviewed for unnecessary medication use. Findings include: Resident # 161 was admitted on 10/15/10 with cumulative diagnoses of status post motor vehicle accident with frontal impact and subarachnoid hemorrhage. The Hospital Discharge Summary, dated 10/13/10, indicated Resident # 161 received Seroquel (an antipsychotic medication) 25 milligrams (mg) at bedtime. There was no indication for the use of Seroquel in the discharge summary. The resident's primary care physician completed a history and physical on 10/18/10. Past medical history did not include a diagnosis to validate the use of Seroquel. Current medications listed included Seroquel 25 mg daily. Under the PHYSICAL EXAM, the physician documented under PSYCHIATRIC, that Resident # 161 had no apparent disorder of mood or affect. He added the resident was alert and oriented to person and	F 329	F-329—483.25 (l) DRUG REGIMEN RESIDENT IS FREE FROM UNNECESSARY DRUGS **Compliance Date 4/21/2011** 1. Resident #161 had the medication discontinued by his attending physician. 2. 100 percent audit of resident medications with diagnosis list to assure appropriate justification for the use of the medications. 3. 100% of licensed nurses and medication aides have been trained to document on the Behavior Documentation Sheets to specify demonstrated behaviors as well as contacting the attending physician for diagnosis for ordered medications. The attending physician for the facility was trained regarding documentation of appropriate diagnosis for the use of medications.	

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F 329	Continued From page 7 significantly less oriented to place and time. Under ASSESSMENT, the physician had written dementia, status post subarachnoid hemorrhage. There was no indication for the use of an antipsychotic medication. Nurse's notes were reviewed from 10/15/10 through 10/20/10. There was no documentation of behaviors for Resident # 161. The NURSING PROGRESS NOTE, dated 10/21/10 indicated the resident had no behaviors. On 10/21/10 at 7:35 PM, the nurse's notes indicated Resident # 161 was picking at the covers, was anxious and was stripping off his clothing. There was no indication the nurse attempted to engage the resident in diversional activities. The Admission Minimum Data Set (MDS) for Resident # 161, dated 10/22/10, indicated he had significant cognitive impairment. He was not coded as having signs and symptoms of delirium or behaviors. The resident did not trigger Behavioral Symptoms on the Care Area Assessment Summary. A nurse's note for 10/25/10 at 9:45 PM, indicated Resident # 161 would pick at anything within reach and continued to take off his clothing. There was no documentation intervention or diversion was attempted. On 10/26/10, Resident # 161 was sent to the local hospital for significant hypotension and hypoxia (According to Delmar's Geriatric Nursing Care Plans, Volume 1, Respiratory Status: Gas Exchange, hypotension,restlessness and anxiety	F 329	4. The Director of Nursing, the Assistant Director of Nursing and other Administrative nursing staff will audit the medications and diagnosis lists of residents on a weekly basis x 4 weeks, monthly x 3 months and then quarterly or as determined by the monthly QI committee based on results of the audits. 5. The results of the audits will be reported to the quarterly QA Executive Committee and adjustments to the audits made as determined to maintain compliance.	

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F 329	Continued From page 8 can be symptoms of hypoxia (low oxygenation of the blood)). The discharge summary, dated 10/31/10, indicated the resident had pneumonia. There was no indication in the hospital discharge summary for the use of Seroquel. Nurse's notes dated 11/05/10 at 4:10 PM, indicated Resident # 161 pulled his gown off and pushed the covering back several times. There was no documentation of attempts of diversion. The Physician's Progress Note, dated 11/08/10, indicated Resident # 1 was seen for a rash on his face. Under PSYCHIATRIC, the physician indicated significant dementia. There was no indication on the progress note for the use of an antipsychotic. The diagnosis was herpes zoster (otherwise known as shingles- a painful, blistering skin rash. Pain can cause anxiety and restlessness). Review of nurse's notes between 11/08/10 and 11/11/10, did not indicate Resident # 161 had exhibited any behaviors. On 11/10/10, the resident was seen by the physician again for significant agitation. The physician added the resident was frequently seen to be stripping off his clothes. Under PSYCHIATRIC, the physician documented the resident had significant dementia and that Resident # 161 was not agitated at the time of the exam. The plan was to increase the Seroquel to 25 mg twice daily. Progress Notes for the Interdisciplinary Care Plan team from 11/05/10 through 01/07/11 were reviewed. There was no indication the resident had behavioral symptoms. There were no	F 329		

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F 329	Continued From page 9 interventions to treat any behavioral symptoms discussed and there was no indication the resident received an antipsychotic medication. During the consultant pharmacist DRUG REGIMEN INITIAL REVIEW,dated 11/18/10, the pharmacist questioned the indication for the antipsychotic medication. The November 2010 DOCUMENTATION of BEHAVIOR sheet did not indicate Resident # 161 had exhibited any behaviors. On 12/01/10, at the request of the pharmacist, via Pharmacy request, the resident's physician indicated the indication for use of the antipsychotic medication for Resident # 161 was depression (on 11/10/10 the physician indicated the Seroquel was for anxiety). A NURSING PROGRESS NOTE,dated 12/02/10, indicated the resident had no behavioral symptoms. The assessment for 12/30/10 also indicated Resident # 161 exhibited no behaviors. The PHARMACIST CHART REVIEW, dated 12/16/10, indicated Resident # 161 had "visual hallucinations shakes on floor." Nursing notes, nursing progress notes, physician progress notes or Documentation of Behavior sheets indicated visual hallucinations. On 01/21/11, the NURSING PROGRESS NOTE, indicated Resident # 161 had no behaviors. The 90 day Assessment, dated 01/21/11, indicated the resident was severely cognitively impaired. The assessment did not code Resident # 161 as having behavioral symptoms.	F 329		

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F 329	Continued From page 10 The DOCUMENTATION of BEHAVIOR SHEET for December 2010 did not indicate Resident # 161 had behaviors. Review of Social Work Progress Notes from 11/01/10 through 01/05/11 did not indicate Resident # 161 exhibited behaviors. DOCUMENTATION OF BEHAVIOR SHEETS,dated for January and February 2011 did not have behaviors coded for Resident # 161. The resident's care plan with a date of 02/22/11, did not address any behaviors for Resident # 161. Physician orders for March 2011 included Seroquel 25 mg twice daily. An observation was made on 09/23/11 at 9:07 AM. Resident # 161 was lying quietly in bed with his eyes open. The resident was observed "picking" at the sheets. An observation was made of the resident on 03/23/11 at 4:07 PM. The resident was sitting quietly in a geriatric chair. On 03/24/11 at 8:49 AM, Resident # 161 was lying in bed. No behaviors were observed. At 10:15 AM, the resident remained in bed. No behaviors were observed. An interview was held with Nursing Assistant (NA) # 1 on 03/24/11 at 10:22 AM. The NA has worked at the facility for 2 years and is familiar with the resident, caring for him on the 7 to 3 shift. The NA stated the resident did not have any types of behaviors. The NA stated the resident had not	F 329		

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F 329	Continued From page 11 exhibited behaviors as far as she knew since admission. She stated the resident did not hit, kick, refuse care or disrobe. She stated the resident was alert and could respond when spoken to, but could not perform any activities of daily living. An interview was held with Nurse # 2 on 03/23/11 at 2:06 PM. She stated resident behaviors were documented on the Documentation of Behavior Sheet, especially if on medication such as Ativan, Risperdal, Seroquel. Nurse # 2 identified Seroquel as an antipsychotic medication that would be given for behaviors including screaming, yelling out, kicking, or resisting care. Documentation either needs to be in the documentation of behavior sheet or the nurse's notes. Nurse # 2 stated Resident # 161 did have behaviors. The nurse added when the resident was first admitted he wore an abdominal binder to keep him from pulling his feeding tube out. An interview was held with the Director of Nursing (DON) on 03/24/11 at 2:41 PM. The DON stated indications for antipsychotic use include schizophrenia, bipolar, psychosis, hallucinations, delusions, and excessive agitation to a point self harm is possible. The DON stated nurses were expected to document behaviors in the nurse's notes and in the DOCUMENTATION of BEHAVIOR sheet. The DON stated if a resident experienced a change in behavior, the expectation was for the nurses to assess for urinary tract infection or pain. If a resident was removing clothes, the DON stated she expected the nurse to take into account the temperature of the room before giving or increasing medication. After reviewing the documentation, the DON acknowledged the documentation did not justify	F 329		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON REHABILITATION & HEALTHCARE CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12 the use of an antipsychotic medication. The nurse that wrote the notes describing the resident's behavior was not available for interview.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the strength of the quaternary sanitizing solution in the three-compartment sink system at levels acceptable to the facility. The facility also failed to remove dried food from and discard sectional plates with chipped dividing walls. Findings include: 1. At 9:23 AM on 03/23/11 the cook ran a measuring cup through the three-compartment sink sanitizing system so she could use it in the preparation of cornbread. At 9:25 AM on 03/23/11 two small baking pans were drying on the draining board of the three-compartment sink system. Two pots, two tray pans, one bowl, two plastic containers, and	F 371		

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F 371	Continued From page 13 utensils were in the quaternary sanitizing solution of the three-compartment sink. The solution was clear without any tint or clouding. A strip used to check the strength of the sanitizing solution only registered 150 parts per million (PPM). At this time, the dietary employee operating the sink reported the strip should read 200 PPM. She stated the small baking pans had already been run through the three-compartment sink system. This employee also commented she thought there had been problems with the sanitizing solution dispensing system at the three compartment sink in the last month. At 9:28 AM on 03/23/11 the quaternary sanitizing solution in the three-compartment sink system was remade. A strip used to check the strength of the solution registered 200 PPM. At 9:32 AM on 03/23/11, after surveyor intervention, the small baking pans on the draining board were run back through the three-compartment sink sanitizing system. At 9:50 AM on 03/23/11 three tray pans and two small baking pans were in the quaternary sanitizing solution of the three-compartment sink. A strip used to check the strength of the solution only registered 150 PPM. At this time, the dietary employee operating the three-compartment sink stated the solution should register at least 200 PPM. At 11:23 AM on 03/23/11 the service representative for the kitchen sanitizing systems stated he thought the dietary staff was adding water to the quaternary solution in the three-compartment sink. He explained, after making adjustments, the quaternary solution now	F 371	F-371—483.35 (I) FOOD PROCURE, STORE/PREPARE/SERVE—SANITARY **Compliance Date 4/21/2011** 1. The Quaternary sanitizing solution was corrected to proper strength immediately upon recognition. 2. The system that titrates the sanitizing solution into the three compartment sink is maintained by Ecolab, who provides professional provider of sanitation services to commercial kitchens. The system was reviewed and calibrated during survey by the Ecolab technician. 3. 100 percent of the kitchen staff was trained to test for proper concentration of the sanitizing solution in the three compartment sink to include that the system is set to release the	

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F 371	Continued From page 14 being dispensed through the hose into the sink registered 200 - 300 PPM when a strip was placed directly under the hose. At 3:28 PM on 03/24/11 the facility's dietary manager (DM) stated she held in-services with her dietary staff at least once a month. She commented the dietary staff was trained to fill the sanitizing sink of the three-compartment system only with the quaternary solution running from the hose of the dispenser. According to the DM, the service representative had been out to repair the three-compartment sink system several times in the last couple of months due to problems. She explained one time the sanitizing solution ran continuously after the dispensing knob was activated, and one time no sanitizing solution would come out of the hose when the dispensing knob was activated. The DM reported her staff was trained to check sanitizing solutions every two hours with strips to make sure they were strong enough. She stated the strip readings were recorded on a log. At 3:33 PM on 03/24/11 a dietary employee commented there had been problems with the three-compartment sink recently, but she was not aware of any abnormal strip readings when the sanitizing solution in the sink system was checked. She stated strips used to check quaternary sanitizing solutions should register 200 - 400 PPM. The employee also reported staff was to check the strength of sanitizing solutions every two hours, and the solutions were to be remade when they became cloudy or dirty. 2. During inspection of kitchenware, beginning at 11:06 AM on 03/23/11, 11 of 32 sectional plates had dried food particles on them, and 10 of 32	F 371	proper concentration of solution without diluting. 4. The sanitizing solution will be tested and the test results recorded on the audit tool in the kitchen to include date, time of test, results of test and who tested. The Certified Dietary Manager will monitor the audit tool to assure compliance, and will perform random solution audits daily x 1 month, then weekly x 1 month, then random audits thereafter. 5. The results of the audits will be presented to the Quarterly QA committee and adjustments to the audits made as determined to maintain compliance. 1. All 11 damaged plates cited were discarded immediately 2. 100 percent audit of plates in the kitchen was conducted to assure no other damaged plates were found.	

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F 371	Continued From page 15 sectional plates had chips in their dividing walls. In addition, 1 of 32 sectional plates was cracked along the dividing wall and bottom of the plate. At 3:28 PM on 03/24/11 the facility's dietary manager (DM) stated she held in-services with her dietary staff at least once a month. She commented the dietary staff was trained to notify the DM when damaged kitchenware was found. The DM explained, if the damage could cause harm to residents and there was money in the budget to order replacements, then the kitchenware was disposed of. The DM commented chipped and cracked kitchenware could cause residents to get cut or could provide a place for bacteria to harbor. According to the DM, it was the responsibility of all dietary employees to check kitchenware for damages. She reported the last inspection point for the kitchenware should be the trayline where the cooks placed food into the kitchenware. The DM stated the employee removing sanitized kitchenware from the dish machine and the cooks were supposed to check the kitchenware for dried food particles. She explained if dried food particles were found in/on kitchenware, the kitchenware was to be run back through the dish machine or three-compartment sink system to clean and re-sanitize it. At 3:33 PM on 03/24/11 a dietary employee commented the DM had to okay the disposal of damaged kitchenware, and even it could not be thrown away, the kitchenware was not used or replaced with alternate kitchenware which was acceptable. The employee stated all dietary staff was responsible for checking kitchenware for damages and dried food particles, but the cooks who placed food in the kitchenware and the	F 371	3. 100 percent in-service of kitchen staff regarding the discarding of chipped and cracked plates. The in-service to include assuring plates are clean before being stored. 4. Random audits of the plates in the kitchen will be conducted by the Certified Dietary Manager or designee daily x 1 month, weekly x 1 month, monthly x 3 months or as determined by the monthly QI committee. 5. The results of the audits will be presented to the quarterly QA committee and adjustments to the audits made as determined to maintain compliance.	

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F 371	Continued From page 16 employees placing sanitized kitchenware up to dry, after exiting the dish machine, were the most likely employees to find chipped, cracked, and dirty kitchenware. She commented chipped and cracked kitchenware could cut residents or make them sick when bacteria collected in the compromised surfaces.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on pharmacist interview and record review the facility's consultant pharmacist failed to report to or make recommendations to the facility for 1 of 10 sampled residents (Resident # 161) who received an unjustified antipsychotic. Findings included: Resident # 161 was admitted on 10/15/10 with cumulative diagnoses of status post motor vehicle accident with frontal impact and subarachnoid hemorrhage. The Hospital Discharge Summary, dated 10/13/10, indicated Resident # 161 received Seroquel (an antipsychotic medication) 25	F 428		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 17 milligrams (mg) at bedtime. There was no indication for the use of Seroquel in the discharge summary. The resident's primary care physician completed a history and physical on 10/18/10. Past medical history did not include a diagnosis to validate the use of Seroquel. Current medications listed included Seroquel 25 mg daily. Under the PHYSICAL EXAM, the physician documented under PSYCHIATRIC, that Resident # 161 had no apparent disorder of mood or affect. He added the resident was alert and oriented to person and significantly less oriented to place and time. Under ASSESSMENT, the physician had written dementia, status post subarachnoid hemorrhage. There was no indication for the use of an antipsychotic medication. Nurse's notes were reviewed from 10/15/10 through 10/20/10. There was no documentation of behaviors for Resident # 161. The NURSING PROGRESS NOTE, dated 10/21/10 indicated the resident had no behaviors. On 10/21/10 at 7:35 PM, the nurse's notes indicated Resident # 161 was picking at the covers, was anxious and was stripping off his clothing. There was no indication the nurse attempted to engage the resident in diversional activities. The Admission Minimum Data Set (MDS) for Resident # 161, dated 10/22/10, indicated he had significant cognitive impairment. He was not coded as having signs and symptoms of delirium or behaviors. The resident did not trigger Behavioral Symptoms on the Care Area	F 428	F 428—483.60 (c) DRUG REGIMEN REVIEW **Compliance Date 4/14 /2011** 1. On 4/6/11 the Seroquel for Resident #161 was discontinued by the attending physician. 2. On 4/4/11, the pharmacy's Regional Clinical Manager generated a list of all facility residents with antipsychotic orders from the pharmacy computer system. The Regional Clinical Pharmacy Manager verified that all residents had an appropriate documented indication for antipsychotic therapy through a focus on-site review. 3. The pharmacy's Regional Clinical Manager trained the Consultant Pharmacist regarding compliance with monthly on-site chart reviews.	

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

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F 428	Continued From page 18 Assessment Summary. A nurse's note for 10/25/10 at 9:45 PM, indicated Resident # 161 would pick at anything within reach and continued to take off his clothing. There was no documentation intervention or diversion was attempted. On 10/26/10, Resident # 161 was sent to the local hospital for significant hypotension and hypoxia (According to Delmar's Geriatric Nursing Care Plans, Volume 1, Respiratory Status: Gas Exchange, hypotension,restlessness and anxiety can be symptoms of hypoxia (low oxygenation of the blood)). The discharge summary, dated 10/31/10, indicated the resident had pneumonia. There was no indication in the hospital discharge summary for the use of Seroquel. Nurse's notes dated 11/05/10 at 4:10 PM, indicated Resident # 161 pulled his gown off and pushed the covering back several times. There was no documentation of attempts of diversion. The Physician's Progress Note, dated 11/08/10, indicated Resident # 1 was seen for a rash on his face. Under PSYCHIATRIC, the physician indicated significant dementia. There was no indication on the progress note for the use of an antipsychotic. The diagnosis was herpes zoster (otherwise known as shingles- a painful, blistering skin rash. Pain can cause anxiety and restlessness). Review of nurse's notes between 11/08/10 and 11/11/10, did not indicate Resident # 161 had exhibited any behaviors. On 11/10/10, the resident was seen by the	F 428	4. 100 percent of licensed nurses were trained regarding the documentation of a diagnosis for all medications ordered for each resident. 5. Beginning with the April 2011 medication regimen review, the consultant pharmacist will provide the facility with a list of all residents that receive antipsychotic therapy and note the supporting documentation supporting justification for that therapy or specify action taken to obtain that justification. This information will be provided to and reviewed by the facility's QI team monthly for three months and then as directed by the QA Executive Committee based on the results of the audits.	

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F 428	Continued From page 19 physician again for significant agitation. The physician added the resident was frequently seen to be stripping off his clothes. Under PSYCHIATRIC, the physician documented the resident had significant dementia and that Resident # 161 was not agitated at the time of the exam. The plan was to increase the Seroquel to 25 mg twice daily. Progress Notes for the Interdisciplinary Care Plan team from 11/05/10 through 01/07/11 were reviewed. There was no indication the resident had behavioral symptoms. There were no interventions to treat any behavioral symptoms discussed and there was no indication the resident received an antipsychotic medication. During the consultant pharmacist DRUG REGIMEN INITIAL REVIEW,dated 11/18/10, the pharmacist questioned the indication for the antipsychotic medication. The November 2010 DOCUMENTATION of BEHAVIOR sheet did not indicate Resident # 161 had exhibited any behaviors. On 12/01/10, at the request of the pharmacist, via Pharmacy request, the resident's physician indicated the indication for use of the antipsychotic medication for Resident # 161 was depression (on 11/10/10 the physician indicated the Seroquel was for anxiety). A NURSING PROGRESS NOTE,dated 12/02/10, indicated the resident had no behavioral symptoms. The assessment for 12/30/10 also indicated Resident # 161 exhibited no behaviors. The PHARMACIST CHART REVIEW, dated	F 428		

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F 428	Continued From page 20 12/16/10, indicated Resident # 161 had "visual hallucinations shakes on floor." Nursing notes, nursing progress notes, physician progress notes or Documentation of Behavior sheets indicated visual hallucinations. On 01/21/11, the NURSING PROGRESS NOTE, indicated Resident # 161 had no behaviors. The 90 day Assessment, dated 01/21/11, indicated the resident was severely cognitively impaired. The assessment did not code Resident # 161 as having behavioral symptoms. The DOCUMENTATION of BEHAVIOR SHEET for December 2010 did not indicate Resident # 161 had behaviors. Review of the Pharmacist Chart Review, dated 01/21/11, did not indicate recommendations were made or questions asked by the pharmacist regarding the increase in the dose of Seroquel in the absence of behaviors. DOCUMENTATION OF BEHAVIOR SHEETS,dated for January and February 2011 did not have behaviors coded for Resident # 161. The Pharmacist Chart Review for 02/16/11 was reviewed. There were no questions or recommendations made regarding Resident # 161's Seroquel. An observation was made on 03/23/11 at 9:07 AM. Resident # 161 was lying quietly in bed with his eyes open. The resident was observed "picking" at the sheets. An observation was made of the resident on	F 428		

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F 428	Continued From page 21	F 428		

03/23/11 at 4:07 PM. The resident was sitting quietly in a geriatric chair.

On 03/24/11 at 8:49 AM, Resident # 161 was lying in bed. No behaviors were observed. At 10:15 AM, the resident remained in bed. No behaviors were observed.

An interview was held with Nurse # 2 on 03/23/11 at 2:06 PM. She stated resident behaviors were documented on the Documentation of Behavior Sheet, especially if on medication such as Ativan, Risperdal, Seroquel. Nurse # 2 identified Seroquel as an antipsychotic medication that would be given for behaviors including screaming, yelling out, kicking, or resisting care. Documentation either needs to be in the documentation of behavior sheet or the nurse's notes. Nurse # 2 stated Resident # 161 did have behaviors. The nurse added when the resident was first admitted he wore an abdominal binder to keep him from pulling his feeding tube out.

An interview was held with the consultant pharmacist on 03/24/11 at 2:22 PM. She stated the indications for the use of an antipsychotic medication were included in the OBRA (Omnibus Budget Reconciliation Act) guidelines. The pharmacist added depression alone was not listed in the OBRA guidelines. When completing the monthly chart reviews, the pharmacist stated she reviewed behaviors documented, diagnoses, any psychiatric consults and nurse's notes. The consultant pharmacist refused to answer when asked if Seroquel was justified for Resident # 161. The pharmacist stated the reason she did not question the Seroquel increase for the resident was because she assumed the Seroquel was working since there were no behaviors

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 22 documented. An interview was held with the Director of Nursing (DON) on 03/24/11 at 2:41 PM. The DON stated indications for antipsychotic use include schizophrenia, bipolar, psychosis, hallucinations, delusions, and excessive agitation to a point self harm is possible. The DON stated nurses were expected to document behaviors in the nurse's notes and in the DOCUMENTATION of BEHAVIOR sheet. The DON stated if a resident experienced a change in behavior, the expectation was for the nurses to assess for urinary tract infection or pain. If a resident was removing clothes, the DON stated she expected the nurse to take into account the temperature of the room before giving or increasing medication. After reviewing the documentation, the DON acknowledged the documentation did not justify the use of an antipsychotic medication.	F 428		

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

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	345145	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/14/2011

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. RECEIVED MAY 09 2011 This STANDARD is not met as evidenced by: Surveyor: 10904 A. Based on observation the doors to the following rooms failed to latch when closed , 111,46 and 59. B. the doors to rooms 42 and 31 on the skilled and ICF wing were very hard to close. 42 CFR 483.70 (a)	K 018	K018 Compliance Date MAY 26, 2011. 1. The Maintenance Director repaired doors 111, 59, 46, 42 and 31. They now close and latch per standard. 2. The facility Maintenance Department conducted a 100 % audit of facility resident room doors to see they closed per standard. Doors identified as nonconforming have been corrected. 3. Facility maintenance, facility administrative personnell and/or designees will audit facility resident room doors weekly for ten weeks and quarterly thereafter to ensure ease of door movement and proper closure. Problems identified shall be referred to Maintenance for correction and follow up. 4. The results of the door audits shall be maintained by the Maintenance Department Head or designee. The log shall be reviewed at the facility QI and Safety Committee meetings each month. Problems identified will be addressed for follow up and correction. K029 Compliance Date MAY 26, 2011. 1A. The facility notified its corporate Maintenance Department of Life Safety's determination. 1B. The trash can was removed at once; the employee was re-in serviced regarding such practice. 2A. No other areas in the facility are non-conforming with this Standard.	5-26-11
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029	2B. The service corridor was audited for other doors similarly propped open; none were found. 3A. The facility corrected the dryer room and brought it into compliance. Advanced Fire Design corrected the problem identified in the Life Safety Survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Samantha Adams 5-6-2011

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON REHABILITATION & HEALTHCARE CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1 option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 10904 A. Based on observation on 04/14/2011 the laundry was not covered by a sprinkler system and the area houses the gas fired dryers. This area must be both one (1) hour construction and fully sprinkled. B. The door to the dryer area was being held open by a trash can. 42 CFR 483.70 (a)	K 029	3B. 100% of the personnell who work in the area of the service corridor have been in-serviced to refrain from propping doors open. 4A. Any problems with the fire safety control and sprinkler system are referred immediately to facility maintenance and/or outside contractors for review and repair. Fire drills are held once per quarter per shift. Results are reported to the facility QI and Safety Committee meetings each month. Problems identified will be addressed for follow up and correction. 4B. Facility maintenance personnell and/or designees shall audit, once per week for ten weeks and thereafter quarterly, the service corridor for doors that have been propped open. Those found to be propped open will be closed properly and the employee cautioned. Repeat offenders will be subject to discipline. Audit results will be forwarded to the Safety and QI Committees for review, discussion and possible intervention.	
K 032 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 10904 A. Based on observation on 04/14/2011 there were exit doors that were very hard to open. a. the exit door at the skilled boiler room b. the exit door near room 34 42 CFR 483.70 (a)	K 032	K032 Compliance Date MAY 26, 2011. 1A. The exit door nearest the boiler room was repaired to make open and closing easier. 1B. The exit door nearest room 34 was repaired to make open and closing easier. 2 The facility conducted 100% audit of all exit doors to determine ease of ingress and egress. No other facility exit doors were located that were difficult to open or close. 3 Facility maintenance, facility administrative personnell and/or designees will audit facility exit doors weekly for ten weeks and quarterly thereafter to ensure ease of door movement and closure. Problems	5-26-11

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

PRINTED: 04/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING 02 - BUILDING 02 B. WING ______	04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON REHABILITATION & HEALTHCARE CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 10904 A. Based on observation on 04/14/2011 the door to Central Supply and Transportation did not close and latch as required. 42 CFR 483.70 (a)	K 029	identified are referred to Maintenance for correction as soon as practicable. 4. The results of the audits shall be maintained by the Maintenance Department Head or designee. The log shall be reviewed monthly at the facility QI and Safety Committee meetings. Problems identified will be addressed for follow up and correction. K029 Compliance Date MAY 26, 2011. 1. The door to Central Supply is repaired. 2. The facility Maintenance Department audited all room doors in the facility to see that they closed per standard. Doors identified as nonconforming have been corrected. 3. Facility Maintenance shall audit the door to Central Supply and Transportation once per week for ten weeks and quarterly thereafter. Problems identified are referred to Maintenance for correction as soon as practicable. 4. The results of the ongoing facility audits for violation of this Standard shall be maintained in the Maintenance Department by the Maintenance Department Head or designee. The log shall be reviewed at the facility QI and Safety Committee meetings each month. Problems identified will be reviewed for appropriate follow up action.	5-26-11
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 10904 A. Based on observation on 04/14/2011 the staff interviewed did not know about the door release master switch at the nurses station. B. The master switch was concealed behind a rack of charts.	K 038	K038 Compliance Date MAY 26, 2011. 1A. The nurse in question was re-educated on the spot about the master door release switch. 1B. The charts obscuring the master release switch were moved- the switch is now visible.	5-26-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] 5-6-2011
TITLE
(X6) DATE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING 02 - BUILDING 02 B. WING	04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON REHABILITATION & HEALTHCARE CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 1 42 CFR 483.70 (a)	K 038	2A. There are no other master door release switches in the facility. The facility Administrator, Maintenance Personnell and/or Administrative personnel conducted a 100 percent in-service of current employees on the master release switch. 2B. There are no other master door release switches in the facility to conceal. The facility Administrator, Maintenance Personnel and/or Administrative personnell conducted a 100 percent in-service of current employees on the master release switch. 3A. The facility has in-serviced 100% of its nursing personnell on the function and location of the master release switch. Facility Maintenance Personnell and/or Facility SDC shall audit staff about the location and function of the master release switch weekly for ten weeks and thereafter quarterly. 3B. Facility Maintenance Personnell, Facility SDC shall audit the master release switch checking to see the switch is in plain view once per week for ten weeks and thereafter quarterly. 4A. The results of facility audits shall be maintained by the Maintenance Department Head or designee. The log shall be reviewed monthly at the facility QI and Safety Committee meetings. Problems identified will be reviewed for appropriate follow up action such as additional training and/or in-servicing. 4B. The results of facility audits shall be maintained by the Maintenance Department Head or designee. The log shall be reviewed at the facility QI and Safety Committee meetings each month. Problems identified will be reviewed for appropriate follow up action such as additional training and/or in-servicing	