STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to provide for care of the toenails for 1 (#124) of 1 sampled resident dependent on staff for activities of daily living Findings include: Resident #124 was admitted to the facility on 08/10/09. Cumulative diagnoses include dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/03/11, indicated the resident was severely impaired cognitively; had no behaviors; required extensive staff assistance for bed mobility; transfers and eating; and, was totally dependent on staff for dressing, toileting, personal hygiene and bathing. The resident was assessed to be incontinent of bowel and bladder. Review of the resident's care plan, dated 02/11/11, identified a problem with Activities of Daily Living. The care plan listed an intervention for ADLs to provide total care for hygiene and grooming. On 05/11/11 at 9:15 AM an observation was made of Resident #124 receiving a bed bath by	F 312	Tower Nursing and Rehabilitation Center 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. Tower Nursing and Rehabilitation Center's 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, Tower Nursing and Rehabilitation Center has the right to refute any of the deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other Administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/23/11

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F 312	Continued From page 1 Nurse Aide (NA) #1. During the bath observation when the NA removed the cover over the resident's legs and feet, Resident #124 toes were observed to be drawing inward and the toenails were growing, approximately one fourth of an inch, over the top of the second, third and fourth toes of both feet. The great toes of both feet were noted to be very thick. NA #1, when asked who cared for the toenails, relayed the resident received care from the podiatrist and she was unsure of when the podiatrist came. An interview, on 05/11/11 at 9:47 AM, was conducted with NA #1. She relayed the resident's toenails are trimmed by the podiatrist and the Social Worker (SW) kept the list of the residents to be seen by the podiatrist. Review of Resident #124's medical record revealed the resident had not had been seen by the podiatrist in the past year. An interview, on 05/11/11 at 3:30 PM, was conducted with the SW. The SW confirmed he maintained a list of resident for the podiatrist. He indicated the podiatrist would see the residents he saw on his last visit and also residents referred by staff. When the SW was asked if Resident #124 was on the list, he confirmed that she was. When asked if she was being seen because she had seen the podiatrist on his last visit or due to a staff member referring her, he indicated he would check. On 05/11/11 at 3:50 PM, at the request of the Administrator, a meeting was held with the Administrator, Director of Nursing (DON) and the SW in the DON's office. The Administrator	F 312	F 312 The Attending Physician ordered Podiatry services for resident #124 on 5-11-2011. Resident # 124 received Podiatry services on 5-13-2011 and will continue services as needed or appropriate. The ADON, QI Nurse, and RN Supervisor completed a 100 percent audit on 5-11-2011 of all resident toenails to assure residents in need of toe nail trimming or Podiatry services were addressed as appropriate. Residents identified as needing Podiatry services are scheduled for the June 2011 Podiatry visit. All Nurses and Nursing Assistants were inserviced by the SDC beginning on 5-11-2011 regarding resident nail care and importance of reporting resident podiatry or nail care needs to the Nurse and/or Social Worker as appropriate. The Social Worker will continue to coordinate Podiatry services under the supervision of the Administrator.	6/3/11

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F 312	Continued From page 2 relayed the podiatrist saw the residents he had seen on his previous visit and then those residents who were referred by staff. She indicated, however, there was a limited number the podiatrist was able to see at each visit; but the resident would be seen on the podiatrist's next scheduled visit. The SW shared the resident had been referred late this morning to be seen by the podiatrist. The DON stated she had viewed the resident's toenails; confirmed they were overly long and growing over the top of the toe. She stated she would have expected the resident's toenails to have been trimmed. On 05/11/11 at 5:00 PM, at the request of the DON, a meeting was held in Resident #124 with the resident ' s physician and the DON. Upon entering the room, the Quality Assurance nursing was sitting at the end of the resident's bed and had attempted to slightly trim the second, third and fourth toe of the resident's left foot. The toe nails of the second, third and fourth toe of the left foot were observed to be rough at the edge. The resident's physician remarked about the toe growing inward, and confirmed the nails were long and were growing over the top of the toe. The physician stated the resident needed to have the nails cut and should be seen by a podiatrist to cut them because of the way the nails were growing.	F 312	The Treatment Nurse will review any residents identified by staff and randomly audit residents for need of nail care or Podiatry services one time weekly for four weeks then one time monthly for three months utilizing a nail care QI audit tool form. The DON will review the nail care QI audit tool form weekly for four weeks then one time monthly for three months to assure continued compliance. The Executive Quality Improvement Committee will review audit results monthly for monitoring and/or recommendations towards continued compliance in this area.	

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #7VFH11	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/23/11

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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
	345513	A. BUILDING 01 - BUILDING I B. WING	06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

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K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72 9.7.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/15/11 at approximately noon the following automatic sprinkler system components were observed as non-compliant: specific findings include; two new tampers on system 2 accelerator was not yet wired in.	K 061	K061 The two new tampers on system two accelerator were installed on 6-16-2011 by Charles Taylor Electric. A 100% audit was completed by the Maintenance Director to ensure that no other accelerators had loose, damaged wires or wires that needed to be wired. The Maintenance Dept. has been in-serviced on the importance of assuring all tampers are wired per life safety code standards on 6-28-2011. The sprinkler contractor will check for any deficient areas to include tampers during their inspections quarterly. The Executive Quality Improvement Committee will review inspections every quarter to assure continued compliance in this area.	7/30/11
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/15/11 at approximately noon the facility's cooking system was not protected in accordance with NFPA 96 - Ventilation Control and Fire Protection of Commercial Cooking Operations. Specific findings include: A. The kitchen ansul system was last inspected in November 2010. Inspections shall be held every six months. B. The deep fryer was located next to a prep serving area without the required splash guard in the dietary kitchen.	K 069	K069 The kitchen Ansul system was inspected on 6-16-11. The splash guard for between the deep fryer and preparation area was purchased on 6-27-11. It will be installed immediately upon receipt. The Maintenance staff was in-serviced that the kitchen Ansul system must be inspected every six months on 6-28-2011. The Executive Quality Improvement Committee will review bi-annual inspections of the ansul system for continued compliance in this area.	7/30/11
K 072	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7/1/11

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DRW

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	345513	A. BUILDING 01 - BUILDING 1 B. WING _____	06/15/2011

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K 072 SS=D	Continued From page 1 Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/15/11 at approximately noon the following means of egress was observed as non-compliant: specific findings include; lifts plugged into the exit corridor. One lift at the end of the green hall and one in the blue hall.	K 072	K072 Lifts were removed from the end of green hall and blue hall and placed in the appropriate storage room within the facility. A 100% audit was completed to assure that no stationary equipment is placed near or impeding any exit egress. All areas noted to be clear. The Maintenance Director was in-serviced on the importance of monitoring all exit egress areas on 6-28-2011. All staff was in-serviced on the importance of maintaining clear and safe egress areas to include the appropriate location to store lifts within the facility. The Maintenance Director will monitor all exits to ensure exit egress areas are clear of obstruction or impediments utilizing a QI audit tool three times a week for four weeks. The Executive Quality Improvement Committee will review the audits for continued compliance in this area.	7/20/11
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/15/11 at approximately noon the following operational inspection and testing was non-compliant Specific findings include: documentation for monthly load test was	K 144	K144 The facility is requesting a 14 week waiver to allow for the replacement of a 100 KW Diesel generator with 72 hour subbase tank 16 light remote annunciator appropriate. Installation date will be by September 15, 2011. CTE Electrical Inc. and Life Safety Systems will be installing the generator.	

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K 144	Continued From page 2 conducted without recording percent rated load or temperature rise. A load bank test had not been completed within the past year. NFPA 99 3-4.4.2 Record keeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110 6-4.2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. NFPA 110 6-4.2.2 (1999 edition) Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPPS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. (load bank testing)	K 144		

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	345513	A. BUILDING 02 - BUILDING II B. WING _____	06/15/2011

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K 038 SS=D	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: 42 CFR 483.70(a) By observation on 6/15/11 at approximately noon the following exit access doors were observed as non-compliant. specific findings include; door leading from the courtyard into the physical therapy was locked from egress.	K 038	K038 The door leading from the courtyard into the physical therapy area will have a secure care unit installed on this door to allow for utilization and egress ability. All other doors in the facility meet the K038 requirements.	7/30/11
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are	K 066	K066 Ashtrays of non combustible material and safe design were purchased for the smoking area on 6-27-2011. The Maintenance Director will audit the smoking area to assure that the appropriate ash trays are in the smoking area three times a week for four weeks using a QI Audit tool. The Executive Quality Improvement Committee will review the results of the audits for continued compliance in this area.	7/30/11

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K 066	Continued From page 1 readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 10/1/09 at approximately noon the following smoking regulations was observed as non-compliant: specific findings include; ashtrays of noncombustible material and safe design per paragraph 3 above were not provided.	K 066		