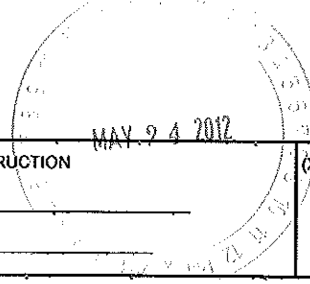

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to update the care plans when 2 of 14 sampled residents (Resident #23 and #28), whose care plans were reviewed, experienced changes in condition. Based on family interview, staff interview, and record review the facility also failed to invite the responsible party to care plan meetings for 1 of 2 sampled residents (Resident #67) whose families were interviewed. Findings include: 1. Resident #23 was admitted to the facility on	F 280	Colony Ridge Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Colony Ridge Nursing and Rehabilitation Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings.	5/31/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Arlene B. Palmer TITLE: Administrator (X6) DATE: 5/18/12

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 280	Continued From page 1 12/23/11 and discharged home on 03/31/12. The resident's documented diagnoses included hypertension and history of myocardial infarction and deep venous thrombosis. The resident's Weight Record documented she weighed 117.25 pounds on 12/27/11, 111.75 pounds on 01/02/12, 109 pounds on 01/09/12, and 107.5 pounds on 01/17/12. Between 12/27/11 and 01/17/12, in less than a month, Resident #23 experienced a 8.3 % weight loss. Resident #23's care plan identified, "At risk due to low albumin and protein, NCS/NAS (no-concentrated sweets/no-added salt) diet with fluid restriction of 1,000 ml (milliliters) daily" as a problem on 01/04/12. Record review revealed Resident #23's nutrition care plan was never updated to reveal the resident experienced significant weight loss, greater than 5% in one month. At 11:12 AM on 05/03/12 the Minimum Data Set (MDS) Coordinator stated resident care plans were to be updated at least quarterly, following the completion of quarterly, annual, or significant change MDS assessments. However, she reported significant changes in condition such as falls, the development of new pressure ulcers, or the emergence of significant weight loss should be captured on the care plans immediately. She explained sometimes this meant updating the care plans with new information as soon as it was discovered. The coordinator commented the dietary manager (DM) was responsible for updating care plans related to nutrition, such as weight loss or increased risk of nutritional decline.	F 280	**F 280** **A) Resident #23 was discharged home on 3/31/12.** **Resident #67 and his responsible party were invited by the Social Worker to attend a care plan meeting on 5/9/12.** **The responsible party attended the care plan meeting on 5/9/12 at 1 P.M. and signed the Interdisciplinary Care Plan form.** **On 5/17/12 the Wound Care Nurse revised Resident #28's care plan to reflect the two wounds merging in the sacral area. The goal was also changed.** **B) An audit of all resident care plans was completed by the MDS Coordinator and the MDS Assistant on 5/14/12 to ensure all changes in condition were addressed.** **An audit was completed by the Social Worker on 5/18/12 to ensure all residents/responsible parties have been invited to a recent care plan meeting. On 5/9/12 care plan invitations for the current month were delivered or mailed to the residents/responsible parties by the Social Worker.**	**5/31/12**

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F 280	Continued From page 2 At 11:28 AM on 05/03/12 the DM stated when Resident #23 was present in the facility care plans were updated manually, as opposed to electronically which became effective 04/01/12. Therefore, she explained in the "manual system" care plans were updated only during/following care plan meetings which were held quarterly. The DM reported she would update resident care plans if they experienced a significant weight loss, but in the old system, that would not have occurred until the next care plan meeting. At 11:50 AM on 05/03/12 the Director of Nursing (DON) stated her expectation was for care plans to be updated within 72 hours of a change in condition, whether that involved an improvement or deterioration. She reported the DM was responsible for updated care plans which pertained to nutrition/hydration. According to the DON, even if residents were care planned for being at nutritional risk, she expected their care plans to be updated immediately if they experienced significant weight loss. 2. Resident #67 was readmitted to the facility on 03/28/12 from the hospital. The resident's documented diagnoses included dementia, congestive heart failure, atrial fibrillation, and diabetes. Record review revealed a 04/04/12 Admission Minimum Data Set (MDS) assessment was completed for Resident #67. Review of the resident's active electronic and paper medical record revealed there was no documentation of a care plan meeting associated	F 280	**F 280** **B) continued** **The MDS Coordinator will distribute a monthly care plan schedule to all all members of the Interdisciplinary Care Plan team. The Social Worker will then mail or deliver invitations to the residents/responsible parties. As proof, invitation copies will be kept in a binder and a Care Plan Invitation tool will be maintained by the Social Worker. The MDS Coordinator will review the proof to ensure compliance.** **C) Individual Inservices were conducted by the Administrator with the Certified Dietary Manager (on 5/11/12) and the Wound Care Nurse (on 5/15/12) to address their responsibility for updating care plans of residents who experience changes in condition in their areas of expertise.** **On 5/9/12 the Administrator conducted an inservice with the Social Worker regarding the regulation that all residents and responsible parties must be invited to the care plan meetings.**	**5/31/12**

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F 280	Continued From page 3 with the 04/04/12 MDS assessment. At 12:53 PM on 04/30/12, during an interview with Resident #67's responsible party (RP), the RP reported she had never been invited to a care plan meeting held for the resident. She commented she thought this was unusual because she had friends with loved ones who were residing in nursing homes, and they talked about attending care plan meetings which provided a chance to share concerns about resident care. She reported the facility should not have any difficulty reaching her because they had a record of her address, phone numbers, and she visited the facility frequently to spend time with the resident. At 3:32 PM on 05/02/11 the facility's social worker (SW) stated she had been documenting the date and time of the care plan meetings, the family/resident and staff in attendance, and information discussed during the meetings on her green Social Progress Notes. However, she reported with the new electronic record keeping process which went into effect 04/01/12 she was not sure where she was supposed to be documenting this same care plan meeting information. According to the SW, the MDS nurses notified her when care plan meetings were due, and then she (the SW) sent out invitations to the families/residents and set up times for the meetings. The SW stated she was unable to find any documentation of a care plan meeting concerning Resident #67 or a copy of an invitation to the meeting. She commented she remembered talking with the RP about Resident #67, but not in a formal meeting setting.	F 280	**F 280** **C) continued** **On 5/11/12 the Administrator conducted an inservice with the MDS Coordinator and the MDS Assistant regarding their responsibility for ensuring care plan updates/changes are made to include changes in condition. The inservice also included the MDS Coordinator providing to the Interdisciplinary Team and a schedule of care plan meetings due and following up to ensure the residents/responsible parties are invited.** **The MDS Coordinator or the MDS Assistant will monitor daily the Point Click Care reports for changes in condition. Care plans will be revised by the appropriate discipline if needed. Findings will be discussed at the daily clinical meetings.**	**5/31/12**

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F 280	Continued From page 4 At 3:44 PM on 05/02/11 the MDS Coordinator stated the electronic Interdisciplinary Care Plan Progress Form documented Resident #67's care plan meeting was to be set up for 04/17/12. However, she reported she could find no documentation that the meeting was ever held. The MDS Coordinator commented she had been printing some of the Interdisciplinary Care Plan Progress Forms out and documenting on them who attended the conferences and any concerns expressed. However, she reported she could not find a form for Resident #67 with this information documented on it. According to the MDS Coordinator, MDS was responsible for setting the date of the care plan conference, but the SW mailed out invitations to the conference and set up a time for it. At 8:37 AM on 05/03/12 the Director of Nursing (DON) stated she was not usually involved in the care plan meetings, but the MDS nurses were supposed to set up the dates for the meetings, relay this information to the SW, and the SW mailed out invitations and established a time for the meetings to be held. The DON reported she was unaware of any changes in how or the location where information about actual care plan conferences was to be documented even after the implementation of an electronic record keeping system on 04/01/12. 3. Resident #28 was readmitted to the facility on 12/24/11 with cumulative diagnoses of congestive heart failure, hypothyroidism, chronic obstructive pulmonary disease, hypertension, and dementia.	F 280	**F 280 continued** **D) A "Change in Condition" audit tool will Be completed by the MDS Coordinator or MDS Assistant monthly x 3 then quarterly x 3.** **The Social Worker will maintain a Care Plan Invitation audit tool monthly.** **The Executive QI Committee will review the results of monitoring for changes in condition/revision of care plans and the results for Care Plan Invitations monthly x 3 then quarterly x 3 for identified trends, necessary follow-up and to determine the need for, or frequency of, continued monitoring.**	**5/31/12**

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F 280	Continued From page 5 A quarterly Minimum Data Set (MDS) assessment completed on 03/12/12 documented Resident #28 was at risk for pressure ulcer development and had two stage 2 pressure ulcers present. Resident #28's care plan, last updated 04/11/12, listed actual skin breakdown under the problem heading with areas present on the right and left buttocks and on the left heel. Goals were for the present areas not to worsen and not to develop any new areas by the next review. A wound care sheet reviewed on Resident #28 indicated a stage 3 pressure ulcer on the sacral area which measured 8 cm (centimeters) by 6.1 cm with a 0.5 depth and slough tissue present on the wound. Physician orders reviewed on Resident #28 revealed an order on 04/23/12 for a wet to dry dressing to be applied to the sacral decubiti. On 04/25/12, there was a physician's order for an indwelling urinary catheter due to a stage 3 sacral pressure ulcer. A wound care observation done 05/01/12 at 10:35 AM revealed a large sacral wound stage 4 with approximately 10% slough tissue in the anterior sacral wound and open area stage 2 wounds present on the right and left buttocks attached to the sacral wound. Resident #2 had a stage 2 area approximately 2.5 cm by 2.5 cm on her left heel and on her right heel a fluid filled purplish blister approximately 3 cm by 3 cm. In an interview with the Wound Care Nurse on	F 280		

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F 280	Continued From page 6 05/03/12 at 9:15 AM, she said Resident #28's wounds on her right and left buttocks started worsening around 04/09/12 and on 04/16/12, the wounds merged into a stage 3 wound to include the sacral area. The Wound Care Nurse said she provided a written weekly wound care log and all wounds were discussed in a weekly facility meeting held on Thursdays. The Wound Care Nurse said she was not sure who was responsible to update a resident's care plan. During an interview with MDS Nurse #1 and MDS Nurse #2 on 05/03/12 at 11:15 AM, they said resident care plans should be reviewed and updated whenever there was a significant change MDS as well as quarterly and annual. MDS Nurse #1 said they received a weekly written wound log and probably should have updated Resident #28's care plan to indicate the wound had worsened and merged to the sacral area. In an interview with the Director of Nurses (DON) on 05/03/12 at 11:50 AM, she said her expectation was for resident care plans to be updated with any changes of improvement or decline. The DON said she would expect a care plan to be updated with any significant changes in wounds. The DON said any nurse would be responsible to update the care plan and she would have expected the care plan to be updated within 72 hours after a change.	F 280		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional	F 325		

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F 325	Continued From page 7 status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide timely interventions to prevent further weight loss for 1 of 2 sampled residents (Resident #23) reviewed for nutrition concerns. Findings include: Hospital laboratory results revealed on 12/20/11 Resident #23's albumin level was low at 3.3 grams per deciliter (g/dL), with normal being 3.4 - 5 g/dL. Resident #23 was admitted to the facility on 12/23/11 and discharged home on 03/31/12. The resident's documented diagnoses included hypertension, acute myocardial infarction, gout, and history of deep venous thrombosis. The resident was admitted on 12/23/11 on a 1800 calorie diet with a 1,000 cubic centimeter (cc) fluid restriction. A physician's order on 12/27/11 changed the resident's diet to a regular no-concentrated sweets (NCS), no-added salt (NAS) diet with a 1,000 cubic centimeter (cc) fluid restriction. The resident's Weight Record documented she	F 325	**F 325** **A) Resident #23 was discharged home on 3/31/12.** **B) On 5/17/12 the dietary manager completed an audit of all residents to ensure residents' with nutritional concerns, weight loss or weight gain had appropriate interventions in place.** **The registered dietician (RD) consultant is now able to view all residents with weight loss through the Point Click Care program. The dietary manager will inform the RD monthly of new admissions and referrals using the New Admission and Consultant Referral Form.** **C) On 5/11/12 the administrator inserviced the dietary manager regarding the importance of providing timely interventions for residents with nutritional concerns, weight loss, or weight gain. Included in the inservice was the importance of having the RD consultant provide timely assessments.**	**5/31/12**

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F 325	Continued From page 8 weighed 117.25 pounds on 12/27/11 and 111.75 pounds on 01/02/12. A 01/03/12 Supplemental Assessment Information-Dietary form, completed by the facility's dietary manager (DM), documented "RD (registered dietitian) to eval (evaluate)." The resident's average meal intake was 50%. Resident #23's care plan identified, "At risk due to low albumin and protein, NCS/NAS (no-concentrated sweets/no-added salt) diet with fluid restriction of 1,000 ml (milliliters) daily" as a problem on 01/04/12. Resident #23's 01/05/12 Nutrition Care Area Assessment (CAA) documented , "Will provide resident w/kcal (with kilocalories), protein and 1,000 cc of fluids daily w/med pass and meal trays." The Referral/Eval Needed section documented, "RD to eval." The resident's Weight Record documented she weighed 109 pounds on 01/09/12 and 107.5 pounds on 01/17/12. Between 12/27/11 and 01/17/12, in less than a month, Resident #23 experienced a 8.3 % weight loss. A 01/19/12 Report of Consultation documented, "Here for hospital follow up appt. (appointment). C/O (complains of) decreased appetite & (and) weight loss. Wants to add small amount of salt to food." Recommendations included, "Fine to add small amount of salt to food. Recommend Ensure or Boost shakes." A review of Resident #23's medical record revealed no physician orders or Nurse's Notes	F 325	**F 325** C) continued **On 5/18/12 the Staff Development Coordinator completed an inservice with all licensed nurses and the transportation aide informing them to submit copies of all consultation reports to the Director of Nursing. The Director of Nursing, or Assistant Director of Nursing, will follow-up to ensure recommendations are addressed and orders written as needed.** **Weekly Weight and Wound meetings are being conducted to ensure appropriate interventions are in place for nutritional concerns, weight loss or weight gain. The dietary manager, wound care nurse, MDS Coordinator and Quality Improvement nurse will attend the weekly meetings. Results of the meetings will be shared in the daily clinical meetings.**	**5/31/12**

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F 325	Continued From page 9 regarding the consultation recommendations made on 01/19/12. A 01/23/12 Supplemental Assessment Information-Dietary form, completed by the facility's dietary manager (DM), documented "RD to eval." The resident's average meal intake was 39%. A 01/26/12 New Admission and Consultant Referral Form documented Resident #23 was to be seen on this date for a RD assessment. The RD initialed that she completed an assessment on Resident #23. A review of Resident #23's medical record revealed no RD assessment completed on 01/26/12. The resident's Weight Record documented she weighed 107.25 pounds on 02/02/12. A 02/04/12 Wound/Ulcer Flow Sheet documented Resident #23 was found with a unstageable pressure ulcer on her coccyx. The wound bed was pink with skin peeled off. A daily hydrogel and foam dressing was ordered. On 02/08/12 the Wound/Ulcer Flow Sheet documented the area on the resident's coccyx was intact with a red, yeasty rash. An antifungal agent was ordered. Resident #23 was not seen by the facility's RD until 02/22/12 when she (the RD) documented in Nutritional Line Notes she recommended discontinuing the resident's fluid restriction and liberalizing her diet to regular without sugar and	F 325	**F 325** **D) The dietary manager will complete a Nutritional Status audit on all Residents monthly x 3 and quarterly X 3.** **Results of the Nutritional Status Audit will be reviewed at the Executive QI Committee meeting monthly X 3 and quarterly X 3 for identified trends, necessary follow-up and the need for, or frequency of, continued monitoring.**	5/31/12

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F 325	Continued From page 10 salt restrictions. A 02/24/12 physician ordered discontinued Resident #23's fluid restriction, and placed the resident on a regular diet. The resident's Weight Record documented she weighed 107.5 pounds on 03/05/12. At 4:16 PM on 05/02/12 the dietary manager (DM) stated the RD was in the facility once a month for one day, but was available by phone whenever needed. She explained when the RD made recommendations during her assessments, the Quality Improvement nurse sent them to the primary physician for approval and orders to implement. At 8:37 AM on 05/03/12 the director of nursing (DON) stated on 01/19/12 Resident #23 should have returned to the facility with a copy of her Report of Consultation form from her hospital follow-up appointment. Since there were recommendations on this form, she reported it should have been give to the charge nurse to call the resident's primary physician for approval and orders. According to the DON, if the physician agreed with the recommendations he would issue phone orders to carry them out. She commented if the physician disagreed, she would expect the facility staff to develop alternate interventions to address Resident #23's poor appetite and weight loss. At 8:52 AM on 05/03/12 Nurse #1 stated when residents returned from appointments with recommendations on a Report of Consultation, the hall nurse who received the form called the	F 325		

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COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 325	Continued From page 11 resident's primary physician to obtain verbal orders to put the recommendations in place. She reported if the physician disagreed with the recommendations, the nurse would write a Nurse's Note documenting why the physician disagreed and alternate plans for addressing the problems. (Record review revealed no Nurse's Notes on 01/19/12 or 01/20/12 documenting Resident #23's physician disagreed with the recommendations made on 01/19/12 at a follow-up hospital appointment). At 9:01 AM on 05/03/12 Nurse #2 stated when residents returned from appointments with recommendations on a Report of Consultation, the form was forwarded to the appropriate charge nurse who called the primary physician to get orders. She reported if the physician disagreed with the recommendations, the nurse would write a Nurse's Note documenting why the physician disagreed and alternate plans for addressing the problems. (Record review revealed no Nurse's Notes on 01/19/12 or 01/20/12 documenting Resident #23's physician disagreed with the recommendations made on 01/19/12 at a follow-up hospital appointment). At 10:41 AM on 05/03/12, during a telephone interview with the facility's RD, she stated she was in the building on 01/26/12, but did not have access to the list of residents that she was supposed to see on that date. However, she commented the first assessment she had documented for Resident #23 in her records was completed on 02/22/12. She explained before the electronic record keeping system was implemented on 04/01/12 significant weight losses were based on the weight taken at the	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING ______ B. WING ______	05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 325	Continued From page 12 beginning of a new month if a resident was admitted later in the previous month. According to the RD, this may have been why it took awhile for Resident #23 to show up on the significant weight loss list. At 10:53 AM on 05/03/12 the DM stated once Resident #23's diet was liberalized and her fluid restriction was removed on 02/24/12 she added ice cream, juice, and chocolate milk to the resident's meals. However, she reported she had no documentation of any food additions to the resident's meals before this time.	F 325		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID 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
	345226	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at.42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, and is equipped with North Carolina Speical Locking and has an automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000	Colony Ridge Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Colony Ridge Nursing and Rehabilitation Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings.	7/15/12
K 029 SS=E	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: Based on the observations and staff interview during the tour on 5/31/2012 the following item was observed as noncompliant, specific findings include: The facility had a buildup of dust and lint in the combustion chamber of the gas fired dryers in the laundry. CFR#: 42 CFR 483.70 (a)	K 029	RECEIVED JUN 14 2012	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Arlene B. Palmer
TITLE: Administrator
(X6) DATE: 6/14/12

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.

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

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OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	05/31/2012

NAME OF PROVIDER OR SUPPLIER: COLONY RIDGE NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 430 WEST HEALTH CENTER DRIVE, NAGS HEAD, NC 27959

(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 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: Based on the observations and staff interview during the tour on 5/31/2012 following exit discharge items were observed as noncompliant as the specific findings: The required exits from the 300 and 400 hallways exit onto a raised wooden walkway. There are areas on this walkway where wooden planks need to be replaced to ensure the walkway remains in good repair for exiting to the public way. CFR#: 42 CFR 483.70 (a)	K 038	K 029 1) The dust and lint was removed from the combustion chamber of the gas-fired dryers in the laundry on 5/31/12 by the housekeeping/laundry supervisor. 2) An audit of all dryer combustion chambers was conducted on 6/6/12 by the housekeeping/laundry supervisor to ensure all chambers were free of dust and lint. 3) On 6/14/12 the housekeeping/laundry supervisor conducted an in-service to inform his laundry staff of their responsibility to clean the combustion chamber of the gas-fired dryers daily. Also, the laundry staff was instructed to document daily on a log when the task is completed. 4) The maintenance supervisor or maintenance assistant will complete a weekly clothes dryer checklist and will inspect and clean the combustion chambers if needed. Results of these inspections will be reported to the Executive QI Committee monthly X 3 then quarterly X 3. If further follow-up is determined to be needed, the Executive QI Committee will decide the frequency of monitoring.	7/15/12
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 5/31/2012 following exit discharge illumination was observed as noncompliant as the specific findings include there were no exit discharge lighting on the emergency circuit at the required exits from the	K 045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 045	Continued From page 2 Activities and Therapy rooms. CFR#: 42 CFR 483.70 (a)	K 045	K 038 1) The wooden planks on the raised wooden walkway located at the 300 and 400 hallway exit were replaced on 6/14/12 by the maintenance supervisor. 2) An audit of the wooden planks on the walkway surrounding the entire facility was completed by the maintenance assistant on 6/1/12 determine any areas of concern. 3) On 6/13/12 the administrator in-serviced the maintenance supervisor and the maintenance assistant informing them that exit access must be arranged so exits are readily accessible at all times and walkways are well-maintained. 4) A Physical Plant QI tool will be completed weekly by the maintenance supervisor or maintenance assistant to address any repairs needed and to ensure all walkways are readily accessible at all times. The Executive QI Committee will review the results of monitoring the exit doors monthly X 3 then quarterly X 3 for identified trends, necessary follow-up, and to determine the need for, or frequency of, continued monitoring.	7/15/12
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 5/31/2012 The sprinkler heads installed at smokers back porch were a mix of a quick response sprinkler heads. There were two Red bulb and one Green bulb sprinkler heads in that area. CFR#: 42 CFR 483.70 (a)	K 062		
K 144 SS=E	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: Based on the observations and staff interviews	K 144		

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	345226	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

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K 144	Continued From page 3 on 5/31/2012 the following Life Safety item was observed as noncompliant with the generator annunciator panel, specific findings include: The generator annunciator panel did not give an indication that the generator was running and carrying the load for the Life Safety circuit when tested. CFR#: 42 CFR 483.70 (a)	K 144	K 045 1) As of 6/14/12, the maintenance supervisor has contacted an electrician to install exit discharge lighting on the emergency circuit at the exits leading from the Activity and Therapy rooms into the courtyard. 2) On 6/13/12 the maintenance supervisor completed a 100% exit discharge audit to ensure all exits have discharge lighting. 3) On 6/13/12 the administrator in-serviced the maintenance supervisor and maintenance assistant regarding the regulation that all exit doors with an illuminated exit sign must have exit discharge lighting. 4) The maintenance supervisor, or the maintenance assistant, will complete weekly a QI tool addressing the monitoring of discharge lighting outside all exit doors. Results will be shared with the Executive QI Committee monthly X 3 and quarterly X 3 to ensure compliance. The need for further monitoring will be determined by the committee if necessary.	7/15/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 062	K 062 1) The maintenance supervisor has contacted Sunland sprinkler company. A representative is scheduled to visit the facility 6/18/12 to address the mix of quick response sprinkler heads installed on the smokers' back porch and the installation of appropriate sprinkler heads in that area. 2) On 6/1/12 the maintenance supervisor performed a 100% audit of all sprinkler heads to ensure they are uniform and not mixed. 3) On 6/13/12 the administrator in-serviced the maintenance supervisor and the maintenance assistant regarding sprinkler heads having to be uniform and not mixed (i.e. red bulbs and green bulbs). 4) The maintenance supervisor will complete a sprinkler head QI monitoring tool monthly X3 and quarterly X3. Results will be shared with the Executive QI Committee monthly X 3 and quarterly X 3. Further monitoring will be determined if necessary.	7/15/12

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	345226	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/31/2012

NAME OF PROVIDER OR SUPPLIER: COLONY RIDGE NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 430 WEST HEALTH CENTER DRIVE, NAGS HEAD, NC 27959

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		K 144	K 144 1) The maintenance supervisor scheduled an appointment during the week of June 18, 2012 for Covington Power Services to inspect the generator annunciator panel and make the necessary repairs. 2) The maintenance supervisor conducted a test of the generator on 6/8/12 to ensure there were no other issues. 3) On 6/13/12 the administrator in-serviced the maintenance supervisor and maintenance assistant regarding the regulation that the generator annunciator panel must give an indication the generator is running and carrying the load for the Life Safety circuit when tested.	7/15/12

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	345226	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 144	K 144 (continued) 4) The maintenance supervisor, or maintenance assistance, will complete the Emergency Generator Electrical System QI tool weekly to ensure proper functioning of the generator and of the generator annunciator panel. Results will be reported to the Executive QI Committee monthly X 3 and quarterly X 3. If trends are identified and require necessary follow-up, the need and frequency of further monitoring will be determined.	7/15/12

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
	345226	A. BUILDING 02 - BUILDING 02 B. WING ______	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, and is equipped with North Carolina Speical Locking and has an automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000	K 038 1) The SPARK unit dining/day room courtyard exit gate was repaired by the maintenance supervisor on 6/13/12 and no longer drags on the attached fence. 2) A 100% audit of all exit doors was completed by the maintenance supervisor and maintenance assistant on 6/13/12 to ensure all exit doors are functioning properly and are readily accessible at all times. 3) On 6/13/12 the administrator in-serviced the maintenance supervisor and the maintenance assistant regarding all exit doors being readily accessible and functioning properly at all times. 4) An exit door QI tool will be completed by the maintenance supervisor or maintenance assistant weekly to ensure all exit doors are functioning properly and are readily accessible at all times. The Executive QI Committee will review the results of monitoring the exit doors monthly X 3 then quarterly X 3 for identified trends, necessary follow-up, and to determine the need for, or frequency of, continued monitoring.	7/15/12
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: Based on the observations and staff interview during the tour on 5/31/2012 the following item was observed as noncompliant, specific findings include: The SPARK unit dining/day room courtyard exit gate is dragging on the attached fence. NOTE: the gate locking device did release activation of the fire alarm, release switch at the gate and nurses' station. CFR#: 42 CFR 483.70 (a)	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Arlene B. Palmer	Administrator	6/14/12

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.