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 _____ JUN 22 2012	06/07/2012

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 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, record review and staff interviews; the facility failed to clarify physicians orders and administer medication as prescribed by the physician for 1 (Resident #107) of 10 residents reviewed for medications. Findings include: Resident #107 was readmitted to the facility on 03/08/12 with diagnoses of end stage dementia, chronic obstructive pulmonary disease, anxiety, depression, and status post left hip fracture. A significant change Minimum Data Set (MDS) assessment completed on 04/23/12 identified Resident #107 as having short term and long term memory problems, severe cognitive impairment and on hospice care. Review of Resident #107's clinical record revealed a pharmacy sheet which documented Resident #107's physician ordered Tylenol Arthritis (pain medication) 650 mg (milligrams) one tablet to be given three times a day ordered on 03/28/12. A physician's verbal order slip for Resident #107, dated 03/31/12, ordered Tylenol 650 mg to be given three times daily. Review of Resident #107's April 2012 Medication Administration Record (MAR) documented Resident #107 received Tylenol Arthritis 650 mg	F 281	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.	6/21/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6/21/12

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.

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 _____	06/07/2012

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 281	Continued From page 1 three times a day for the month. The order for Tylenol 650 mg had a line drawn through it noted as a duplicate order. There was no physicians order to discontinue or clarify the medication order. Review of Resident #107's Physician's Orders sheet for May 2012 listed an order for Tylenol Arthritis 650 mg one tablet to be given three times a day ordered on 03/28/12. Another order, on 03/31/12, listed Tylenol 650 mg to be given three times per day. Resident #107's MAR for May 2012 documented Tylenol Arthritis 650 mg was initialed as given three times daily for the month. Tylenol 650mg was initialed as given on 05/01/12 at 9:00 AM, 12:00 PM and 8:00 PM and from 05/02/12 to 05/06/12 at 8:00 PM. The 9:00 AM and 12:00 PM doses from 05/02/12 to 05/06/12 were circled and written on the back of the MAR as not given as duplicate order. It was written on the MAR to discontinue the medication on 05/07/12. There was no physician's order to discontinue or clarify the medication order. A review of June 2012 MAR documented Resident #107 received Tylenol Arthritis three times daily and Tylenol 650 mg three times daily on 06/01/12 and from 06/03/12 to 06/06/12. On 06/02/12, the 9:00 AM and 12:00 PM doses of Tylenol 650 mg the initials were circled. On 06/07/12 the 9:00 AM dose was circled and written on back as not given as duplicate order. In an interview with The Director of Nurses (DON) and the Administrator on 06/06/12 at 4:55 PM, the DON said her expectation was for a nurse to	F 281	F281 Facility Residents to include Resident #107 are receiving services meeting professional standards of quality to include having physician orders clarified and medications administered as ordered by the Resident's Primary Physician. Review of Medication Administration records for Facility Residents to include for Resident #107 from 6-1-2012 forward were reviewed as assigned by the Director of Nursing to the Administrative Nurses to include the Assistant Director of Nursing, Quality Improvement Nurse, Staff Development Coordinator and the Supervisors to ensure Physician orders were clarified, written and transcribed appropriately for changes to medications in order for medications to be administered as ordered. Any concerns identified were addressed at the time of discovery as needed with the appropriate staff by the Administrative Nurse conducting the review.	6/21/12

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 _____	06/07/2012

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 281	Continued From page 2 have contacted the physician for clarification of two Tylenol orders and documented clarification in the resident's record. At 5:20 PM, the DON said she contacted the physician and clarified the order. In an interview with Nurse #1 on 06/07/12 at 10:55 AM, Nurse # 1 said she had circled the Tylenol doses on 05/02/12 to 05/06/12 at 9:00 AM and 12:00 PM and on 06/07/12 at 9:00 AM and wrote not given as a duplicate order on the back of Resident #107's MAR's in May and June. Nurse #1 said she had not written the d/c (discontinue) 05/07/12 on Resident #107's May 2012 MAR and she had not contacted the physician for clarification orders. In a telephone interview with the Consultant Pharmacist on 06/07/12 at 2:10 PM, he said he would question two Tylenol orders for clarification from the physician but as one was a time released formula and one was an immediate release formula and the dosage was less than 4 grams per day, it may be indicated. The Consultant Pharmacist said if both medications had been ordered by the physician, they should be given as ordered.	F 281	All Nurses were in-serviced related to ensuring that Physician Orders are clarified as needed, written and then transcribed to the Medication Administration Record at the time the order is received from the Physician and given as ordered. The in-servicing was conducted by the Staff Development Coordinator beginning on 06/06/12. The in servicing was completed on 06/21/12. A QI Tool will be utilized to reflect audits of Medication Administration Records and Physician Orders as warranted to ensure that corresponding Physician Orders have been clarified, written and transcribed appropriately for changes noted on the Medication Administration Record following professional standards of quality and that medications are being given as ordered. The QI Tools will be completed by an Administrative Nurses to include the Assistant Director of Nursing, Quality Improvement Nurse, Staff Development Coordinator and Supervisors 3 x weekly for minimum of 4 weeks then weekly x 4 weeks then monthly for a minimum of 2 months.	6/21/12
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		

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 _____	06/07/2012

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 315	Continued From page 3 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to assess 1 of 1 sampled residents (Resident #87) who had experienced a decline in urinary and bowel incontinence for participation in a scheduled toileting program. Findings include: Resident #87 was admitted to the facility on 01/05/2010. Cumulative diagnoses included dementia and hypertension. A significant change Minimum Data Set (MDS) assessment of 11/18/11 indicated Resident #87 was frequently incontinent of her bladder and continent of bowel. A quarterly MDS assessment of 12/13/11 indicated Resident #87 was occasionally incontinent of bladder and bowel. There was no toilet program noted on this assessment. A quarterly MDS assessment of 03/06/12 indicated Resident #87 was frequently incontinent of bladder and bowel. There was no toilet program noted on this assessment. Resident #87's care plan, last revised 05/10/12, was reviewed but there was no mention of incontinence. The most recent quarterly MDS assessment of 05/24/12 indicated Resident #87 had long and	F 315	Cont F281 All Audit results will be reviewed weekly by the Quality Improvement Nurse with follow up as deemed necessary for any identified concerns. Results of the QI review will be compiled and forwarded to the Monthly Quality Improvement Committee to include the Administrator and the Director of Nursing for monthly review for identification of trends, development of action plan and to determine the need and / or frequency of continuing QI monitoring. F315 Resident #87 was evaluated for a toileting program on 06/13/2012 by the MDS Nurse and is receiving services as indicated based on the assessment and evaluation. Facility Residents assessments for the past 6 months to include for Resident #87 were reviewed for decline in Urinary or Bowel Incontinence by the MDS Nurses. Residents with a decline were evaluated for participation in a toileting program . Residents deemed appropriate for toileting are receiving services as indicated based on their assessment and evaluation. The evaluations and implementation of Toileting programs were completed for Residents on 06/16/2012	

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 _____	06/07/2012

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 315	Continued From page 4 short term memory loss as well as severely impaired decision making skills. She needed assistance with toilet use and was frequently incontinent of bladder and bowel. There was no toilet program noted on this assessment. Resident #87 was observed in a low bed with her eyes closed on 06/06/12 at 8:25 AM. During an interview with Nurse #1, on 06/07/12 at 9:30 AM, she stated if a resident had a decline in continence status, the aides usually alerted the nurse. She stated she was not aware of any formal toilet programs or bowel/bladder assessments to track residents for changes in continence levels. When questioned about Resident #87's continence status, she stated Resident #87 was totally incontinent due to her age. During an interview with Nurse Aide #1 (NA#1), on 06/07/12 at 9:35 AM, she stated this was her first time working with Resident #87. When questioned about her continence status, she stated she was total care but did not know anything about her previous levels of care. NA#1 added that she usually was bathed on third shift and liked to get up later in the morning. During an interview with the MDS nurse (MDS Nurse #1), on 06/07/12 at 10:00 AM, she stated she was in charge of the restorative nursing program and scheduled toileting was included. MDS Nurse #1 stated that when the MDS assessments were done, she spoke with the nurse aides to see if any changes had occurred with the residents. She commented bowel and bladder habits were discussed during that time.	F 315	The MDS Nurses were in-serviced related to ensuring that Residents are assessed appropriately for participation in a toileting program when a decline in noted in the Resident's Urinary or Bowel Incontinence pattern at the time of their assessment by the Director of Nursing on 06/13/2012. A QI Tool will be utilized to record the review of all facility Resident per the MDS Assessments schedule to ensure that Residents with a decline in Urinary and / or Bowel function have been evaluated for participation in a toileting program as warranted. The QI Tools will be completed by an Administrative Nurses to include the Assistant Director of Nursing, Quality Improvement Nurse or Staff Development Coordinator as designated by the Director of Nursing in comparison to the MDS Assessment schedule weekly for minimum of 4 weeks then monthly for a minimum of 2 months. Audit results will be reviewed weekly by the Quality Improvement Nurse with follow up as deemed necessary for any identified concerns.	

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 _____	06/07/2012

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 315	Continued From page 5 She reported there were 3 residents currently participating in their scheduled toileting program. When questioned about criteria for determining if a resident was a candidate for the program, she stated residents who were occasionally or frequently incontinent would be good candidates for assessment to see if they were appropriate for scheduled toileting. MDS Nurse #1 reported that if a resident did have a decline in their continence status, a diary was placed for staff to document their toileting to see if that resident was a candidate. MDS nurse #1 also stated if a resident was able to verbalize that they needed to use the toilet she considered that another indication that an assessment could be done to see if the resident was appropriate for the program. When questioned about Resident #87, she commented that Resident #87 was able to verbalize her desire to go to the toilet but she was not on a scheduled toileting program and had not been assessed to see if she was a candidate. MDS Nurse #1 commented that Resident #87 was combative at times and was not sure that she would participate but no one had attempted scheduled toileting or retraining. She added that she would assess her to see if she would be a candidate. During an interview with the Director of Nurses (DON), on 06/07/12 at 11:30 AM, she commented that often times Resident #87 yelled out in the hallway "I got to ---" . She stated Resident #87 knew when she needed to go to the bathroom but she was not sure if she would cooperate with staff if placed in a scheduled toileting program. The DON added that she did not remember anyone ever trying her on	F 315	Results of the QI review will be compiled and forwarded to the Monthly Quality Improvement Committee to include the Administrator and the Director of Nursing for monthly review for identification of trends, development of action plan and to determine the need and / or frequency of continuing QI monitoring.	

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 _____	06/07/2012

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 315	Continued From page 6 scheduled toileting. When questioned about the criteria for consideration into the scheduled toileting program, she stated those residents who were able to verbalize their need to toilet or if were continent some of the time should be considered possibilities for inclusion into the program. The DON also stated residents were discussed in the morning meetings and if any had changes, it was passed on to MDS nurse #1 for assessment. She added that Resident #87 had a history of declining and bouncing back.	F 315	F327 Fluid Restriction orders for Resident #18 were discontinued on 06/11/2012 .as ordered by the Resident's primary Physician. All Residents Physician orders were reviewed by Administrative Nurses to include the Assistant Director of Nursing, Quality Improvement Nurse, Staff Development Coordinator and the Supervisors to identify Residents with orders for Fluid Restriction. The audit completed on 06/11/12 All Nurses were in-serviced related to their responsibility to monitor Fluid Restriction as ordered by monitoring the intake records and the amount of fluids consumed by the Resident on a daily basis /every shift if the Resident had orders for Fluid Restriction to ensure that Residents are receiving the proper amount according to their restriction limits. The in-servicing was initiated on 06/13/2012 and was completed on06/21/2012. Provision of Fluids will continue to be routinely monitored each shift by Nursing Staff when orders are	
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to have a system in place to monitor fluid intake for fluids provided by the facility for 1 of 1 sampled residents (Resident #18) who had physician's orders for fluid restrictions. Findings include: Resident #18 was admitted to the facility on 09/28/09. Cumulative diagnoses included end stage renal disease with hemodialysis, diabetes mellitus and dementia. A telephone physician's order of 04/10/12 noted a clarification of Resident #18's fluid restriction of 1500 cubic centimeters (cc) daily. The April 2012 Medication Administration Record	F 327		6/21/12

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 _____	06/07/2012

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 327	Continued From page 7 (MAR) included a 1500 cc fluid restriction daily. It was also written that dietary would provide 640 cc on the 7AM - 3PM shift and 320 cc on the 3PM - 11PM shift. Nursing was to provide 220 cc on the 7AM - 3PM shift, 220 cc on the 3PM - 11PM shift and 100cc on the 11PM - 7 AM shift. The nursing staff had written amounts in the daily blocks but there were no totals noted for each day to indicate the total amount of fluid that Resident #18 actually consumed. There were no daily dietary amounts noted on the MAR to indicate the amount of fluids consumed. Upon review of the April 2012 Meal/Fluid intake sheet for Resident #18, it was noted that he refused breakfast on a regular basis. There were blanks noted on this sheet. There were no daily totals noted. According to MAY 2012 physician order sheet, Resident #18 was to be on a fluid restriction of 1500 cc daily. The May 2012 MAR indicated Resident #18 was to be on a 1500 cc fluid restriction daily. It was noted that the fluid amounts to be provided by nursing were indicated per shift. Resident #18 was to be provided 220 cc on the 7AM - 3PM shift, 220 cc on the 3PM - 11 PM shift and 100 cc on the 11PM - 7AM shift. There were no daily totals to indicate the actual daily consumption for Resident #18. There were no daily dietary amounts noted. The May 2012 meal/fluid intake sheet indicated Resident #18 refused breakfast on a regular basis. It was noted that from 05/21/12 through 05/28/12 there were no entries of fluids	F 327	received for Fluid Restriction. An Administrative Nurses to include the Assistant Director of Nursing, Quality Improvement Nurse, Staff Development Coordinator and Supervisors will monitor intake for those Residents with Fluid Restriction orders to ensure provision of fluids is occurring according to the restricted amount. A QI Tool will be utilized to record the reviews and will be completed 3 x weekly for minimum of 4 weeks then weekly x 4 weeks then monthly for a minimum of 2 months. Audit results will be reviewed weekly by the QI Nurse with follow up as deemed necessary for any identified concerns. Results of the QI review will be compiled and forwarded to the Monthly Quality Improvement Committee to include the Administrator and the Director of Nursing for monthly review for identification of trends, development of action plan and to determine the need and / or frequency of continuing QI monitoring.	

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 _____	06/07/2012

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 327	Continued From page 8 consumed. There were no daily totals noted. The most recent Quarterly Minimum Data Set (MDS) assessment of 05/15/12 indicated Resident #18 had long and short term memory problems as well as severely impaired decision making skills. He rejected care during 1 - 3 days and was able to feed himself with set up from staff. It was noted that he was receiving dialysis. A dietary supplemental assessment of 05/22/12 indicated Resident #18 was on a fluid restriction of 1500 cc daily. There were no daily totals included in this assessment. It was noted that his intake was 1500 cc fluid daily with requirements of 1568 cc fluid daily. During review of Resident #18's care plan, which was provided by the facility on 06/07/12 at 11:30 AM, it was noted that a problem was identified with non-compliance in regard to fluid restrictions on 06/07/12. Interventions included to discuss with the resident implications of not complying with the therapeutic regimen and to document care being resisted. Staff were to notify the physician of those patterns of behavior. Resident #18 was observed sitting in his wheelchair in the dining room on 06/05/12 at 9:30 AM. He was getting a cup of coffee and some crackers. The therapist who pointed him out stated he came into the dining room daily to get his coffee. During an observation of Resident #18's room, on 06/05/12 at 3:19 PM, it was noted that there was a water pitcher on the night table beside the bed. The pitcher was approximately half full of water.	F 327		

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 _____	06/07/2012

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 327	Continued From page 9 On 06/06/12 at 8:00 AM, Resident #18 was observed sitting in his wheelchair in the dining room. He was drinking a cup of coffee and looking out the window. During an observation of Resident #18's room, on 06/06/12 at 10:00 AM, the water pitcher was noted on night table next to bed. The pitcher was approximately half full of water. During an interview with Nurse Aide #2 (NA#2), on 06/06/12 at 4:40 PM, she stated Resident #18 was not on any restrictions in regards to his diet or fluids. She stated he had a water pitcher but she had to pour it for him. NA#2 stated all residents except those on thickened liquids had water pitchers in their rooms. She added that she provided care according to the care guide located in each resident's closet door. NA#3 reported during an interview on 06/06/12 at 4:45 PM that Resident #18 came into the dining room at will to get coffee and crackers. She added that he enjoyed looking out of the window while he drank his coffee. The wound consultant reported on 06/06/12 at 5:25 PM that fluid intake from dietary was tracked on the meal/fluid intake sheets and the nurses tracked what they provided on the MARs. Resident #18 was observed eating dinner in the dining room on 06/06/12 at 5:45 PM. He had an 8 ounce glass of iced tea and a mauve colored cup of coffee. Upon review of his tray slip, it was noted to include 1500 cc with the type of diet. At the bottom of the slip, unsweetened tea was	F 327		

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 _____	06/07/2012

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 327	Continued From page 10 listed for dinner. There was no mention of coffee on the tray slip. The water pitcher was observed again on the night table on 06/07/12 at 8:40 AM. It had been filled with ice. There was a care guide located inside Resident #18's closet door. There was a block to indicate fluid restrictions but it was blank. The dietary manager (DM) was interviewed about fluid restrictions on 06/07/12 at 10:15 AM. She reported that when a resident had physician's orders for a fluid restriction, she calculated how much dietary would provide and how much nursing would provide depending upon the amount of the restriction. The DM stated there were 4 residents currently on fluid restrictions which included Resident #18. She stated the tray slips indicated the amount of the restriction. She stated dietary provided 360 cc on the breakfast tray, 240 cc on the lunch tray and 360 cc on the dinner tray. The DM stated it was nursing's responsibility to keep up with what they provided. When questioned as to who tracked his daily fluid consumption, she remarked she knew how much dietary provided to him but she did not track what he actually consumed. The DM stated if she was aware that a resident was refusing a breakfast meal routinely, she would send a 10:00 AM snack with fluids to that resident. She commented she was not aware that Resident #18 was refusing breakfast but did state he went to the dining room at will to get coffee throughout the day. The DM also commented she felt he was consuming adequate fluids. She also reported on dialysis days, a bag lunch was sent out with him which included a 120 cc juice. The DM stated the juice was not captured anywhere.	F 327		

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 _____	06/07/2012

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 327	Continued From page 11 Nurse #2 was interviewed on 06/07/12 at 9:00 AM. She stated Resident #18 was on a fluid restriction which was captured on the MAR. She added that she documented the amounts she provided to him during medication pass daily. She commented Resident #18 drank 90 cc with his medications today. Nurse #2 stated the nurse aides documented the amounts consumed on the daily flow sheets or in the computer. She added that the nurses totalled their shift amounts. Nurse Aide #4 (NA#4) was interviewed on 0607/12 at 9:10 AM. She stated she worked with Resident #18 and was familiar with him. When questioned about his care needs, she stated she used the care guide located inside his closet door for guidance. She commented that Resident #18 never ate breakfast. NA#4 stated he gets his own fluids but she has to pour the water from his pitcher for him. She commented that he was not on any restrictions in regards to his diet or fluids. NA#4 stated she documented fluid consumed on the resident's tray slip. Resident #18 was observed sitting in his wheelchair in the dining room on 06/07/12 at 9:20 AM. When questioned if he had coffee today, he nodded his head to indicate yes. During an interview with the Director of Nurses (DON) and the Administrator, on 06/07/12 at 11:45 AM, the DON stated nurses were responsible for tracking the fluids provided during medication pass on the MARs. She added that staff were aware of what he was allowed to have but she could not provide any actual totals for the amounts he consumed. The DON and the	F 327		

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 _____	06/07/2012

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 327	Continued From page 12 Administrator both reported Resident #18 to be non-compliant with the fluid restriction order. The Administrator stated he was care planned for his non-compliance as well. She reviewed his care plan which was in the care plan book at the nursing station and stated she did not see it included. She provided an updated care plan as of 06/07/12 which included his non-compliance. The Administrator stated she had no way of knowing how much fluid Resident #18 consumed as he gets his own fluids at will. After discussion, she stated she did not know if anyone was tracking daily fluid consumption for the fluids the facility provided. The DON stated residents who had physician's orders for fluid restrictions were not to have water pitchers at the bedside. She also stated the fluid restriction should be noted on the care guide as well.	F 327		
F 364 SS=E	The facility failed to track fluid intake on 1 of 1 residents on fluid restrictions 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the	F 364	F364 Vegetables for facility resident meals requiring cooking are being prepared without overexposure to heat therefore conserving the nutritional value of the food item. In-servicing was completed for Dietary staff to include Dietary cooks related to proper cooking time frames and holding temperatures for vegetables in order to prevent over exposure to heat by the Dietary Manager on 06/13/2012.	6/21/12

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 _____	06/07/2012

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 364	Continued From page 13 facility failed to preserve the nutrient content of green and orange vegetables by overexposing them to heat during the cooking process. Findings include: During food preparation observation on 06/06/12 at 8:45 AM there were two pots of greens bubbling on the stove. The burners under the pots were set on high, and steam was coming off the vegetables as they were cooking, There was one large and one medium pot of greens on the stove. Whole sweet potatoes were in the upper racks/section of the oven, baking at 250 degrees Fahrenheit. At 9:00 AM on 06/06/12 both pots of greens were stirred, but the burner temperatures were not adjusted. At 9:22 AM on 06/06/12 the sweet potatoes were moved to the lower racks/section of the oven, set at 250 degrees Fahrenheit. At 9:27 AM on 06/06/12 the medium pot of greens, which was still bubbling, was removed from the stove, cooled, and pureed. At 9:35 AM on 06/06/12 the pureed greens were placed into the Steam 'N Hold, set at the maximum temperature of 200 degrees Fahrenheit. At 9:45 AM on 06/06/12 the temperature of the lower racks/section of the oven, where the sweet potatoes were cooking, was increased to 325 degrees Fahrenheit. At 10:10 AM on 06/06/12 the large pot of greens,	F 364	Dietary Manager and Cooks are monitoring temperatures and cooking times for foods to include vegetables with meal preparation. The Dietary Manager will audit for compliance utilizing a QI tool 3 x weekly for 4 weeks, then once weekly for 4 weeks then monthly as directed by the QI Committee. The Administrator will review the results and forward to the monthly QI Committee for review and action as needed and to determine the continuing need and / or frequency of QI monitoring.	

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 _____	06/07/2012

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 364	Continued From page 14 which was still bubbling, was removed from the stove and placed into the Steam 'N Hold, set at the maximum temperature of 200 degrees Fahrenheit. During observation of the 06/06/12 lunch meal in the main dining room between 12:22 PM and 12:35 PM the sweet potatoes were very pulpy and mushy inside, almost a pudding consistency. Review of the facility's standardized recipes revealed the recipe for baked sweet potatoes recommended cooking at 425 degrees Fahrenheit for 40 to 45 minutes, and the recipe for greens recommended steaming or boiling until tender. Review of the facility's Meal Delivery Schedule revealed trayline operation usually ran 45 to 60 minutes. There were no frozen greens still in storage, but review of cooking directions on frozen spinach did not specify a recommended cooking time. The cook who was responsible for cooking the greens and sweet potatoes was not scheduled to work on 06/07/12. At 9:40 AM on 06/07/12 another cook, who was working with the cook on 06/06/12 who was responsible for the greens and sweet potatoes, stated he was not sure when the other cook placed the greens on the stove or placed the sweet potatoes in the oven. However, he reported he would have waited until about 10:00 AM to start cooking his vegetables so they would not have been overcooked.	F 364		

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 _____	06/07/2012

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 364	Continued From page 15 At 9:48 AM on 06/07/12 the dietary manager (DM) stated the lunch trayline began operation at 11:45 AM (which meant the greens and sweet potatoes were exposed to three hours of heat during cooking and one hour of heat on the trayline). She reported the longest she wanted vegetables be be exposed to heat was two hours (including the hour time spent on the steam table during operation of the trayline). According to the DM, the cooking times for different foods were reviewed in past in-services in a general way. She explained dietary staff was instructed to place those foods which required the longest cooking times on the stove/in the oven first, and those which required less cooking time could be put on the stove/in the oven closer to the time the trayline began operation. She commented the staff could prep vegetables the day before or early in the morning the day of being served, but she did not want them exposed to too much heat during cooking because they became very mushy and lost some of their vitamin/mineral content. The DM stated she was unsure why the cook started cooking the greens and sweet potatoes so early, but recalled the cook commenting she wanted the greens to be tender.	F 364		

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 _____	06/26/2012

RECEIVED JUL 13 2012 CONSTRUCTION SECTION

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
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: A. Based on observation on 06/26/2012 there were unsealed penetrations in the ceiling of the Electrical/ Phone room. B. There is a six (6) inch plastic duct for the portable AC unit penetrating the ceiling of the Phone room thatdoes not have a damper protecting the openning. C. There are holes around the pipe penetrating the ceiling of theMech. Room near room 415 42 CFR 483.70 (a)	K 012	Tower Nursing and Rehabilitation Center acknowledges receipt of deficiencies and proposes this plan of correction to the extent that the summary findings are factually correct and in order to maintain compliance with the 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 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. K012 The electrical/phone room were sealed with the correct duct as of 07/09/12 by Maintenance Director.	7/11/12
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: A. Based on observation on 06/26/20012 the inside release for the cooler door was broken and not operable. B. Based on observation on 06/26/2012 the door to the soiled linen room near room 413 required more than one (1) motion of the hand to exit the room. 42 CFR 483.70 (a)	K 038	Damper has been placed 07/03/12 in Electrical/Phone room by Maintenance Director. Holes around the pipes in the mech room was sealed on 07/03/12 by Maintenance Director.. A 100% audit was completed by the Maintenance Director to ensure that no other unsealed penetration the ceiling. QI committee will reivew audits every quarter to assure continued compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7/11/12

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

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 _____	06/26/2012

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
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: A. Based on observation on 06/26/2012 there was an unsecured 02 cylinder on the floor of room 402. 42 CFR 483.70 (a)	K 076	K038 The cooler door was fixed on 06/26/12. by Maintenance Director. The lock on the soiled linen room was replaced on 06/29/12 by the Maintenance Director. The Maintenance Director will monitor all doors using a QI audit tool three times a week for four weeks. QI committee will reivew audits every quarter to assure continued compliance. K076 O2 cylinder was removed and secured 06/26/12 by the Maintenance Director.	7/11/12 7/11/12
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: A. Based on observation on 06/26/2012 the	K 144	A 100% audit was completed by Maintenance Director to assure that All 02 cylinders are secured. The Supply Clerk/ Maintenance Director will monitor all rooms to ensure all cylinders are secure utilizing a QI adult tool three times a week for four weeks. QI committee will reivew audits every quarter to assure continued compliance.	

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 _____	06/26/2012

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
K 144	Continued From page 2 facility had a temp. generator which cranked on the test but failed to transfer power. 42 CFR 483.70 (a)	K 144	K144 The Panel for the generator was replaced On 06/29/12. Generator will continue to be inspected weekly by Maintenance Director .QI committee will reivew audits every quarter to assure continued compliance.	7/11/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING 02 - BUILDING II B. WING _____	06/26/2012

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
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: A. Based on 0observation on 06/26/2012 the generator failed to transfer power with the lose of normal power. 42 CFr 483.70 (a)	K 144	K144 The Panel for the generator was replaced On 06/29/12. Generator will continue to be inspected weekly by Maintenance Director .QI committee will reivew audits every quarter to assure continued compliance.	7/11/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrat — (X6) DATE: 7/11/12

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.