STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345072	A. BUILDING _____ B. WING _____	C 07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA RIVERS NURSING AND REHABILITATION CENTER	1839 ONSLOW DR EXTENSION JACKSONVILLE, NC 28540

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based oin observation and staff interview, the facility failed to provide privacy of personal information of 2 of 13 residents (resident #41 and resident #24) during medication administration.	F 164	Carolina Rivers 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 provision of quality care of the residents. The plan of correction is submitted as written allegation of compliance. Carolina Rivers Nursing and Rehabilitation Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies and the Plan of Correction nor does it constitute an admission that any deficiency is accurate. Further, Carolina Rivers Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding. **F164**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: RN BSN UNHA Admin | (X6) DATE: 8/27/12

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 164	Continued From page 1 1. Resident 41 was admitted to the facility on 2/3/2004 with cumulative diagnosis of chronic airway obstruction, fracture and repair to left hip, peripheral vascular disease, hypertension, reflux, dementia, and cerebral vascular accident. Review of resident #41 Minimum Data Set (MDS) dated 6-1-2012 a quarterly assessment indicated the resident had short term and long term memory problems and had severe impaired cognitive skills for daily decision making. On 7/24/2012 an observation of Nurse #1 revealed at 4:00 pm that she walked away from the medication cart to go down the hall to a medication room and then further down the hall to another nurse ' s medication cart to retrieve some medication. The nurse #1 left the Medication Administration Record (MAR) of resident #41 open with personal information exposed for 2 minutes. The nurse returned to the medication cart continued to prepare the resident medications and walked away from the cart again at 4:05 pm into the resident room and left the MAR open again. Nurse #1 again left the resident personal information exposed for another 3 minutes while she was in the resident #41 room. The medication cart was visible from the room and the door to the room was opened, but the nurse had her back to the door the whole 3 minutes. During this time frame a staff member walking with another resident walked by the medication cart with resident #41 ' s personal information exposed. The resident #41 MAR had been left open with personal information exposed to anyone for a total of 5 minutes. The nurse #1 returned to the medication cart at 4:08 pm and signed the MAR.	F 164	a. The Medication Administration Record (MAR) for residents #41 and #24 were covered post discovery of unprotected personal information by staff nurse. b. The MAR for all other residents was reviewed and protection of personal information was ensured. c. Licensed staff will be retrained by the Staff development Coordinator or designee as of 08/20/2012 regarding protection of personal information during medication administration. d. The Director of Nursing or designee will review MARs during a medication administration time three times per week for four weeks to ensure protection of personal information, then monthly with rounds. Results will be documented and reviewed weekly for four weeks by the Resident Care Committee for identification of trends and follow up as deemed necessary and to determine the frequency and/or need for continued monitoring.	8/20/12

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F 164	Continued From page 2 On 7/26/2012 at 8:40 am an interview with nurse #2 indicated all nurses had been instructed to make sure the MAR is covered or closed when they had walked away from the medication cart to protect the resident personal information. On 7/26/2012 at 9:13 am an interview with the Administrator revealed her expectation had been that all nurses cover the MAR or keep it closed when they had walked away from the mediation cart. The Administrator indicated all nurses had signed a non-disclosure agreement on orientation to the facility that covered release of resident information being written or verbal. The administrator indicated the discloser was reviewed annually and during medication audits randomly. The Administrator indicated the non-disclosure agreement covered topics including the MAR being covered during a medication administration to protect the resident personal information. On 7/26/2012 at 9:19 am in interview with the Director of Nursing (DON) indicated her expectation that nurses had covered or closed the MAR to protect resident personal information from being exposed to others. The DON indicted that the nurses had been instructed during orientation to the facility and during medication audits periodically on protection of resident personal information. On 7/26/2012 at 9:23 am and interview with the Staffing Coordinator indicated that she had taught nurses that any information on the medication carts revolving a resident personal information should have been covered when the nurse had	F 164		8/20/12

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F 164	Continued From page 3	F 164		8/20/12

walked away from the medication cart. The coordinator indicated she covered this information with the nurses during orientation, annually, and when she had done medication audits periodically.

2. Resident #24 was admitted to the facility on 6/4/2012 with cumulative diagnosis of convulsions, depression, heart disease, reflux, persistent mental disorder, and hypertension.

Review of resident #24 Minimum Data Set (MDS) dated 6/13/2012 indicated resident #24 had short term and long term memory problems and severely impaired cognitive skills for daily decision making.

On 7/24/2012 at 4:12 pm an observation of Nurse #1 revealed she had started to prepare medication for resident #24 and walked away from the medication cart and left the MAR open and exposed to others. She was observed to walk down the hall turn the corner and answer a phone call at 4:13 pm and returned at 4:15 pm. During the time away from the medication cart a housekeeper had walked by the exposed MAR.

On 7/26/2012 at 8:40 am an interview with nurse #2 indicated all nurses had been instructed to make sure the MAR is covered or closed when they had walked away from the medication cart to protect the resident personal information.

On 7/26/2012 at 9:13 am an interview with the Administrator revealed her expectation had been that all nurses cover the MAR or keep it closed

MH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 4 when they had walked away from the mediation cart. The Administrator indicated all nurses had signed a non-disclosure agreement on orientation to the facility that covered release of resident information being written or verbal. The administrator indicated the discloser was reviewed annually and during medication audits randomly. The Administrator indicated the non-disclosure agreement covered topics including the MAR being covered during a medication administration to protect the resident personal information. On 7/26/2012 at 9:19 am in interview with the Director of Nursing (DON) indicated her expectation that nurses had covered or closed the MAR to protect resident personal information from being exposed to others. The DON indicted that the nurses had been instructed during orientation to the facility and during medication audits periodically on protection of resident personal information. On 7/26/2012 at 9:23 am and interview with the Staffing Coordinator indicated that she had taught nurses that any information on the medication carts revolving a resident personal information should have been covered when the nurse had walked away from the medication cart. The coordinator indicated she covered this information with the nurses during orientation, annually, and when she had done medication audits periodically.	F 164	**F431** a. The seven expired green top vacutainer tubes were discarded at the time of discovery. b. All other vacutainer tubes were checked; no other expired tubes were noted. c. Licensed staff will be retrained by the Staff Development Coordinator or designee as of 08/20/2012 to check the expiration date of vacutainer tubes prior to use. The day shift Team Leader has been retrained to check vacutainers weekly for four weeks then monthly to discard expired items. d. The day shift Team Leader or designee will check vacutainers weekly for fours weeks, then monthly, with corrective action taken as indicated. The results will be documented and reviewed weekly for four weeks by the Resident Care Committee for identification of trends and follow up as deemed necessary and to determine the frequency and/or need for continued monitoring.	8/20/12
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 5 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that there were no expired items in 1of 4 storage areas (the office behind the 400/500 nursing station.). The findings	F 431		8/20/12

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F 431	Continued From page 6 include: During an observation on 07/25/12 at 3:45 PM of the supervisor office behind the 400/500 nursing station, 7 green top vacutainer tubes (tubes used to obtain blood specimens) were observed to have and expiration date of June 2012. During an interview with the Nurse Facilitator on 07/25/12 at 3:50 PM it was revealed "I would check the supply whenever I would draw blood. The tubes are obtained from the Lab that we use whenever we need to add to the supply. I am the one to check for expiration dates. These are outdated and should not be here."	F 431		8/20/12

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

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	345072	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	10/07/2012 by the administrator. d Facility Maintenance Staff will check corridor doors to include the corridor door to the oxygen storage room and soiled utility room on 600 hall weekly for four weeks then monthly for four months to ensure the corridor doors close with latch and seal. The maintenance supervisor or designee will also monitor the fire damper to ensure it is in appropriate repair monthly with fire drill. These findings will be reviewed in the Safety Committee meeting monthly for three months and follow up as deemed necessary and to determine the frequency and/or need for continued monitoring.	11/7/12
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 8/23/12 at approximately 11:00 AM the following was noted. 1) The corridor door to the soiled utility room on 600 hall was not self closing. 42 CFR 483.70(a)	K 029		
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have	K 061	K061 a. The line in question has been determined to be a water line per Sunland Fire Protection not a sprinkler line. No repair necessary.	

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

Administrator 9/7/12

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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	345072	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/23/2012

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K 061	Continued From page 1 valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 8/23/12 at approximately 11:00 AM the following was noted. 1) The is a valve on the branch line for the dry sprinkler system off of the main line in the attic on 600 hall that was not electronically supervised. 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 061	K066 a. A metal container with a self-closing cover has been placed in the approved smoking areas as of 10/07/2012 by the facility maintenance staff. b. All approved smoking areas have inspected with metal containers with self-closing cover has been placed as indicated as of 10/07/2012 by the facility maintenance staff. c. Facility maintenance staff have been retrained regarding need for metal containers with self-closing cover devised into which ashtrays can be emptied are readily available to all approved smoking areas by the administrator as of 10/07/2012. d. The facility maintenance supervisor or designee with check all approved smoking areas weekly for four weeks then monthly with rounds to ensure metal containers with self-	10/1/12
K 066 SS=D	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are	K 066	closing covers at	IV

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	345072	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA RIVERS NURSING AND REHABILITATION CENTER	1639 ONSLOW DR EXTENSION JACKSONVILLE, NC 28540

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K 066	Continued From page 2 readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation on Thursday 8/23/12 at approximately 11:00 AM the following was noted. 1) A metal container with a self-closing cover into which ashtrays can be emptied in the smoking area per paragraph 4 above was not provided. 42 CFR 483.70(a)	K 066	maintained in approved smoking areas as indicated. These findings will be reviewed in the Safety Committee meeting monthly for three months and follow up as deemed necessary and to determine the frequency and/or need for continued monitoring.	11/7/12
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation on Thursday 8/23/12 at approximately 11:00 AM the following was noted. 1) The high level combustion air inlet behind the dryer was being used as an exhaust vent and the lower level was not maintained clean and good condition.	K 067	K067 a. The high and low level combustion air inlet behind the dryer will be inspected and repaired by an outside agency as indicated as of 10/07/2012. b The high and low level combustion air inlet behind the dryer will be inspected and repaired by an outside agency as indicated as of 10/07/2012. c. Facility maintenance staff will be retrained to inspect the high and low level combustion air inlets for proper working condition with routine rounds by the administrator as of 10/07/2012.	
K 144 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised	K 144		V

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K 144	Continued From page 3 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 observation on Thursday 8/23/12 at approximately 11:00 AM the following was noted. 1) Upon testing the emergency generator the transferred switch did not function when the power was switched from normal to emergency. 42 CRC 469.70(a)	K 144	d. The high and low level combustion air inlet will be inspected weekly for four weeks the monthly for three months by the facility maintenance supervisor or designee to ensure it is maintained in clean and good condition with repairs made as indicated. These findings will be reviewed in the Safety Committee meeting monthly for three months and follow up as deemed necessary and to determine the frequency and/or need for continued monitoring. K144 a. The transfer switch on the emergency generator will be serviced by an outside agency by 10/07/2012 with repairs made as indicated. b. The generator will be inspected by an outside agency as of10/07/2012	10/7/12

10/7/12

with adjustments made accordingly.

c. Facility Maintenance staff will be retrained by the administrator as of 10/07/2012 on requirements for emergency transfer of power for the generator.

d. Facility maintenance supervisor or designee will check the generator weekly for four weeks to ensure emergency transfer of power occurs within 10sec of loss of power, then monthly thereafter. These findings will be reviewed in the Safety Committee meeting monthly for three months and follow up as deemed necessary and to determine the frequency and/or need for continued monitoring.

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

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SEP 10 2012
CONSTRUCTION SECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345072	A. BUILDING 02 - BUILDING 02 B. WING	08/23/2012

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CAROLINA RIVERS NURSING AND REHABILITATION CENTER	1839 ONSLOW DR EXTENSION JACKSONVILLE, NC 28540

(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 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Carolina Rivers 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 provision of quality care of the residents. The plan of correction is submitted as written allegation of compliance. Carolina Rivers Nursing and Rehabilitation Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies and the Plan of Correction nor does it constitute an admission that any deficiency is accurate. Further, Carolina Rivers Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	10/7/12
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD Is not met as evidenced by: Based on observation on Thursday 8/23/12 at approximately 11:00 AM the following was noted. 1) A fire damper is need at the ceiling in the electrical room were the vent for the air conditioning unit is located. 2) The corridor door to the oxygen storage room did not close, latch and seal when checked. 42 CFR 483.70(a)	K 029	K029	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [illegible] RN BSN LNHA
TITLE: Administrator
(X6) DATE: 9/7/2012

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.

PRINTED: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

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
	345072	A. BUILDING 02 - BUILDING 02 B. WING _____	08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA RIVERS NURSING AND REHABILITATION CENTER	1839 ONSLOW DR EXTENSION JACKSONVILLE, NC 28540

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			a. A fire damper will be placed in the electrical room were the vent for the air conditioning unit is located by an outside agency by 10/07/2012. The corridor door to the oxygen storage room and the corridor door to the soiled utility room on the 600 hall has been adjusted and is closing properly with latch and seal by facility maintenance staff as of 10/07/2012. b. All other corridors doors have been checked as of 10/07/2012 by facility maintenance staff, and are closing with latch and seal as indicated. No other areas are identified as having issue with lack of fire damper. c. Facility maintenance staff has been retrained regarding closure of corridor doors with latch and seal, and of need for approved automatic fire extinguishing system where applicable as of	10/7/12