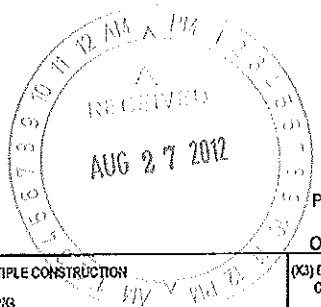

PRINTED: 08/07/2012
FORM APPROVED
OMB NO. 0938-0391

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
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interviews with staff and resident, and record reviews the facility failed to	F 157	Haymount Rehabilitation and Nursing 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 the plan of correction does not denote agreement with the citation by Haymount Rehabilitation and Nursing 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cheryl M. Riddle	Administrator	8/22/12

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
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2345 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 157	Continued From page 1 notify the physician of 1 of 1 sampled residents (resident #114) about continued complaints of pain and discomfort in the resident's left arm and the dialysis access site resulting in continued use of as needed pain medication. Findings include: Resident #114 was admitted to the facility 4/25/12 and readmitted 5/25/12. Her diagnoses included end stage renal disease. The minimum data set (MDS) assessment dated 5/2/12 revealed resident #114 was cognitively intact. She was not coded for impairment for daily decision making. She required limited one person assistance for bed mobility, transfers, walking, dressing, toilet use, bathing and personal hygiene. She required set up help only for locomotion on the unit and eating. She was not coded for pain or dialysis. A hospital consultation note dated 5/17/12 revealed resident #114 had an arteriovenous (AV) fistula (a surgical connection of an artery and vein for dialysis) placed in her left arm on 3/5/12 due to stage four chronic kidney disease. When she was admitted to the hospital on 5/6/12 her chronic kidney disease had progressed into end stage renal disease and hemodialysis was recommended. The fistula in her left upper arm had not matured for use so a catheter was inserted in her chest for dialysis. Resident #114 was discharged to the facility on 5/25/12 with orders for dialysis three days a week. A physician's order dated 5/26/12 read; Tylenol 650 milligrams (mg) by mouth every six hours as	F 157	F157 Resident #114 was reassessed for pain by the DON and MD was notified of findings. (7/26/12) Resident #114 lefts shunt site was reassessed by the Unit Coordinator on 7/26/12. Resident #114 was reassessed by the PA for pain and effectiveness of pain medication. (7/27/12) Resident was ordered an additional PRN dose of pain medication. (7/26/12) The facility audit was completed by the DON and Administrator of each resident medication record for review of PRN medications. Findings were documented on PRN Audit sheet. (8/10/12) All findings of PRN medication utilized were discussed with the MD. (8/11/12) The MD reviewed all use and PRN medication for resident #114 and all other residents and made changes as needed for each individual resident. (8/11/12) Licensed nursing staff was in-serviced on the PRN policy by the DON and RN supervisor of medications and MD notification of significant changes.	7/26/12 7/26/12 7/27/12 7/26/12 8/10/12 8/11/12 8/11/12 8/15/12

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
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 157	Continued From page 2 needed. A significant change MDS assessment was completed on 6/1/12 and resident #114 remained coded as cognitively intact. She required extensive one person assistance for bed mobility, dressing, bathing and personal hygiene. She required one person limited assistance for transfers, walking, locomotion on the unit, eating and toileting. She was coded to use pain medications as needed and to have moderate, occasional pain. She was also coded for dialysis. A hospital procedure note for resident #114 dated 6/6/12 revealed the left arteriovenous fistulogram demonstrated a moderate degree of stenosis (abnormal narrowing) in the proximal portion of the left upper extremity possibly resulting in the lack of thrill. Balloon angioplasty was performed and there was good result with only minimal residual narrowing. Good flow was seen throughout the entire graft with no focal narrowing or blockage. Resident #114 was discharged back to the facility on 6/6/12. The procedure discharge instructions read; "Left arm restriction; No tight clothing, blood pressure or needle sticks in left arm. Report or call for bleeding, swelling or severe pain in left arm." A nurse's note dated 6/6/12 indicated resident #114 returned from her procedure with a bandage intact on her left upper arm dry and intact with no complaints of pain and no swelling noted. A nurse's note on 6/7/12 read; "resident states left arm tender to touch." A nurse's note on 6/13/12 indicated resident #114	F 157	Ten percent of resident charts will be audited weekly x4, then monthly x3, then quarterly x2 by the DON, Unit Coordinator, or RN designee for notification to MD for significant changes. Ten percent of all resident receiving PRN medication will be audited by the DON and/or Unit Coordinator for usage of PRN medication and notification to the MD. These audits will be conducted weekly x4, then monthly x2, then quarterly. Findings will be submitted to the QA by the DON for any and all findings monthly x3 and then quarterlyx3 and then as needed. Changes will be made by the QA committee as needed and appropriate plan will be implemented by the DON and staff will be re-in serviced to the revised plan by the DON or designee as needed.	8/17/12 8/17/12 & Ongoing 8/2012 and on-going

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
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 157	Continued From page 3 complained of "left arm site pain" and she was medicated with Tylenol. A nurse's note on 6/15/12 revealed resident #114 complained of pain in her "left arm fistula site but not severe" and she was medicated with Tylenol. A nurse's note on 6/18/12 revealed resident #114 was medicated with Tylenol for complaints of left arm soreness. A nurse ' s note on 6/20/12 indicated resident #114 was medicated with Tylenol for complaints of left arm pain. A nurse's note dated 6/22/12 indicated resident #114 complained of left arm pain and was medicated with Tylenol. A nurses note on 6/29/12 read; "resident went to dialysis today came at 530pm with order to go see (physician) d/t (due to) c/o (complaints of) pain in Lt arm access Monday july 2, 2012." Review of the June 2012 medication administration record (MAR) revealed resident #114 received Tylenol 650 mg once a day on 6/11/12, 6/18/12, 6/20/12, 6/21/12, 6/22/12, 6/25/12, 6/26/12, 6/28/12 and 6/30/12. She received Tylenol 650 mg twice a day on 6/12/12, 6/13/12, 6/15/12 and 6/19/12. A physician's progress note from the surgeon's assistant dated 7/2/12 revealed resident #114's left AV fistula was "not working" There was no bruit or thrill. She planned to discuss the findings with the surgeon for a possible procedure to declot (remove the clot in) the AV fistula.	F 157		

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
	346414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 157	Continued From page 4 A nurse's note dated 7/2/12 indicated that resident #114 had returned from her doctor's appointment and quoted the physician assistants note that the fistula was not working and there was no bruit or thrill. A nurse's note dated 7/6/12 indicated the resident was medicated for complaints of AV fistula site pain. A nurse's note on 7/11/12 and 7/13/12 revealed resident #114 was medicated with Tylenol for left arm pain. A nurse's note on 7/20/12 indicated resident #114 was medicated for left hand and left arm pain. Review of the July 2012 medication administration record (MAR) revealed resident #114 received Tylenol 650 mg once a day on 7/2/12, 7/3/12, 7/5/12, 7/6/12, 7/10/12, 7/14/12, 7/15/12, 7/16/12, 7/17/12, 7/23/12 and 7/25/12. She received Tylenol 650 mg twice a day on 7/9/12, 7/11/12, 7/12/12, 7/13/12, 7/18/12, 7/19/12, 7/20/12, 7/24/12 and 7/26/12. The national institute of Health numerical pain scale classified pain from 4-6 as moderate and 7-10 as severe. Review of the July 2012 MAR revealed resident #114 complained of severe pain on 7/16/12 and 7/17/12 and moderate pain on 7/9/12, 7/10/12, 7/11/12, 7/12/12, 7/18/12, 7/19/12, 7/20/12, 7/24/12, 7/25/12 and 7/26/12. Pain was not assessed and the site of the pain was not documented every time Tylenol was administered.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 157	Continued From page 6 Review of a facility policy titled "PRN Orders" read; "PRN (on request or as needed) orders shall be used as little as possible. If a resident uses a PRN medication repeatedly over several days or longer, the nursing staff will discuss with the physician whether the current medication remains appropriate, whether other or additional medications are indicated, whether any additional evaluation is needed, or whether a standing order would be more appropriate." On 7/24/12 at 2:20 PM resident #114 was observed in bed in her room. She frowned as she rubbed her left arm and shoulder. She said her left arm had hurt since early June when she had a procedure on her AV fistula. She indicated she received Tylenol for pain almost every day but it did not help much. On 7/26/12 at 8:50 AM the resident was interviewed. She stated her left arm had hurt from her shoulder to her fingertips daily since the AV fistula procedure in early June. She described her pain as "excruciating" at times and said she could only take Tylenol for the pain due to her heart. She indicated that Tylenol helped temporarily. Resident #114 said her left arm pain had negatively impacted her life. She said she felt depressed and tired all the time because she did not sleep well at night due to the pain in her left arm. She said some days she could not brush her hair or button her shirt due to the pain in her left arm. She explained that she was left handed but has had to learn to use her right arm to feed herself because her left arm was painful. Resident #114 held both of her arms straight out in front of her and made a fist with both hands. The fist on the right hand closed tightly but the fist	F 157		

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
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 157	Continued From page 6 on the left hand was not fully closed. She reported it was too painful to make a light fist with her left hand. She said a lot of times she just dealt with the pain on her own because she felt no one had helped her. On 7/26/12 at 10:37 AM nurse #1 was interviewed. She indicated that resident #114 was alert and oriented and cognitively intact. When asked about the resident's left arm pain she stated "something was done to her left arm, was not sure what had been done." She said resident #114 had received Tylenol for pain almost daily but she had never called the physician. She said she had reported the resident's left arm pain to the unit supervisor but could not recall when she reported it. On 7/26/12 at 11:56 AM nurse #2 was interviewed. She said she worked second shift and was often the nurse who received resident #114 back from dialysis. When asked about resident #114's left arm pain, nurse #2 said the resident usually complained of pain around a level 8. She said she did not notify the physician because he was already aware of the resident's left arm pain and that the fistula was not working. Nurse #2 also reported "last week" resident #114 complained of left hand numbness and said she (nurse #2) did not notify the physician. Nurse #2 could not explain why she did not notify the physician. On 7/26/12 at 12:25 PM nurse #3 was interviewed. She said she worked weekend days with resident #114. She said the resident occasionally complained of left arm pain. Nurse #3 said she had not contacted the physician	F 157		

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
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2349 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 157	Continued From page 7 because resident #114 had only occasionally complained of left arm pain to her. On 7/26/12 at 1:05 PM the unit supervisor was interviewed. She said 7/26/12 was the first time she had been informed of resident #114's left arm pain. She said had she known she would have called the physician and informed him. On 7/26/12 at 2:40 PM the Director of Nursing (DON) was interviewed. She said she expected the nursing staff to contact the physician for continued complaints of pain, continued use of as needed pain medications or if pain medications were ineffective. On 7/27/12 at 11:10 AM the facility physician was interviewed. He said he could not recall or find documentation that anyone from the facility had notified him of resident #114's left arm pain. He said he expected the facility to notify him if a resident used as needed pain medication for several consecutive days so that they could discuss the need for a routine pain medication. He also expected the facility to notify him for a resident who complained of continued pain.	F 157		
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	F 164		

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
	346414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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	Continued From page 8 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 on observation, interviews and facility record review the facility failed to move 1 of 4 sampled residents (resident #91) dependent for repositioning to a private area to reposition him. Findings include: Resident #91 was admitted to the facility on 2/1/12. His diagnosis included a cerebral vascular accident (stroke) with left sided paralysis. The quarterly minimum data set assessment dated 5/8/12 for resident #91 revealed he was cognitively intact. He required extensive assistance of two people for bed mobility and was	F 164	F164 Social Worker met with resident #91 regarding Resident rights and Resident safety. (7/27/12.) Care plan meeting was held with resident and his responsible party regarding resident rights and safety by the Care plan team on 8/2/12. Residents requiring assistance were identified through the MDS. Department Heads will monitor resident dignity and privacy during Weekly Round Checks. Findings will be documented on the Resident and Room Audit Sheet. by the Dept Head assigned. Findings will be corrected and addressed by the Dept. Head immediately on rounds. Licensed staff and C.N.A.'s were in-serviced on Resident Rights and Dignity by the Social Worker. Dietary, Therapy, and Housekeeping staff in-serviced by Social worker and/or their Department Manager. Licensed staff and C.N.A.'s not in-serviced by the Social worker will be in-serviced upon return to work by the DON or RN designee. New employees (licensed nurses and c.n.a.'s) will be in-serviced upon hire during orientation and annually thereafter by the Social Worker or DON.	7/27/12 8/2/12 8/16/12 8/16/12 and on-going 8/16/12 8/16/12 and on-going 8/16/12 and on-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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	Continued From page 9 dependent on two people for transfers. He had range of motion impairment in bilateral upper and lower extremities. Resident #91's care plan dated 2/8/12 identified he required staff assistance for all activities of daily living related to impaired mobility. There were no interventions related to repositioning. On 7/26/12 at 1:00 PM resident #91 was observed in a high back wheelchair by the 100, 200 and 300 hall nurses station in no danger of falling. There were four residents, two facility staff members and a visitor in the immediate area. Nursing assistant (NA) #1 was stopped by a member of the maintenance staff as she pushed a resident through the hall of the nurse's station. NA #1 walked over to resident #91, stood behind his wheelchair and told him she was going to reposition him. NA #1 reclined the back of resident #91's wheelchair approximately thirty five degrees, she placed each of her arms under his arms and slid him up in the chair then returned the back of his wheelchair to its previous upright position. NA #1 moved around to resident #91's right side and pulled him to the right and placed a pillow under his left shoulder and upper arm then repositioned a pillow behind his neck. On 7/26/12 at 1:05 PM resident #91 stated that he had rather go to his room to be repositioned, "it can be embarrassing." Resident #91 indicated he asked to be repositioned for comfort. He said NA #1 did not ask him if he wanted to return to his room before she repositioned him. On 7/26/12 at 1:18 PM NA #1 indicated she was told by maintenance staff that resident #91 asked	F 164	Documented findings from the Weekly Round Check sheet will be reviewed weekly x4 by the Administrator for any negative findings. Findings will be submitted to the QA by the Administrator n=monthly x3 and quarterly thereafter. Changes will be made by the QA Committee as needed and staff will be re-in serviced by the Social Worker to the revised plan as needed.	8/24/12 8/2012 and on-going

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
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2345 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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	Continued From page 10 to be repositioned. She said she should have moved resident #91 to a private area such as his room to reposition him. NA #1 stated residents should be repositioned in their rooms to respect their privacy and dignity and she did not think before she repositioned resident #91 in the hallway. On 7/26/12 at 2:38 PM the Director of Nursing indicated her expectation was that residents be repositioned in their rooms and not in the hallways unless it was an emergency situation to prevent a fall.	F 164		
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F 279 Resident #141 care plan was updated on pain. Residents who have pain were identified through the MDS. Ten percent of the residents identified as having pain will have audits conducted by the MDS Coordinator to ensure that a care plan is generated for all residents triggering for pain. Audits will be documented on Monthly Pain Care plan Audit sheet. (8/13/12). All residents were reassessed for pain by the DON and Unit Coordinator. Findings documented on Pain Assessment Sheet in each individual clinical record. (8/8/12; 8/9/12; and 8/13/12). Licensed nurses were in-serviced on Pain Management and Assessment/ Care plans by the DON and RN Designee.	8/13/12 8/13/12 8/13/12 8/13/12 8/13/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2348 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interviews with resident and staff, and record reviews the facility failed to develop a comprehensive care plan for pain for 1 of 1 residents (resident #114) with identified moderate to severe pain in her left arm and frequent use of as needed pain medications. Findings include: Resident #114 was admitted to the facility 4/25/12 and readmitted 5/25/12. Her diagnoses included end stage renal disease. The minimum data set (MDS) assessment dated 5/2/12 revealed resident #114 was cognitively intact. She required limited one person assistance for bed mobility, transfers, walking, dressing, toilet use, bathing and personal hygiene. She required set up help only for locomotion on the unit and eating. She was not coded for pain or dialysis. A significant change MDS assessment was completed on 6/1/12 and resident #114 remained coded as cognitively intact. She required extensive one person assistance for bed mobility, dressing, bathing and personal hygiene and one person limited assistance for transfers, walking, locomotion on the unit, eating and toileting. She was coded to use pain medications on an as needed basis and to have moderate, occasional pain. She was also coded for dialysis. The care plan for resident #114 dated 6/4/12 did not include pain.	F 279	Licensed nurses not in-serviced by the completion date listed above will be in-serviced by the DON on or before next scheduled day of work. All findings will be submitted to the QA committee by the MDS Coordinator monthly x3, then quarterly x2, then as needed thereafter. Necessary changes will be implemented as deemed necessary by the QA committee and licensed nursing staff will be re-in serviced by DON or designee to the revised plan as needed.	8/16/12 8/2012 and On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 12 A physician's order dated 5/25/12 read; Tylenol 650 milligrams (mg) by mouth every six hours as needed. Review of the May 2012 medication administration record (MAR) revealed resident #114 received Tylenol 650 mg once a day on 5/26/12, 5/27/12, 5/28/12, 5/29/12, 5/30/12 and 5/31/12. She received Tylenol 650 mg twice on 5/28/12. Review of the June 2012 medication administration record (MAR) revealed resident #114 received Tylenol 650 mg once a day on 6/11/12, 6/18/12, 6/20/12, 6/21/12, 6/22/12, 6/25/12, 6/26/12, 6/28/12 and 6/30/12. She received Tylenol 650 mg twice a day on 6/12/12, 6/13/12, 6/15/12 and 6/19/12. Review of the July 2012 medication administration record (MAR) revealed resident #114 received Tylenol 650 mg once a day on 7/2/12, 7/3/12, 7/5/12, 7/6/12, 7/10/12, 7/14/12, 7/15/12, 7/16/12, 7/17/12, 7/23/12 and 7/25/12. She received Tylenol 650 mg twice a day on 7/9/12, 7/11/12, 7/12/12, 7/13/12, 7/18/12, 7/19/12, 7/20/12, 7/24/12 and 7/26/12. On 7/26/12 at 8:50 AM the resident was interviewed. She stated her left arm had hurt from her shoulder to her fingertips daily since the AV fistula procedure in early June. She described her pain as "excruciating" at times and said she could only take Tylenol for the pain due to her heart. She indicated that Tylenol helped temporarily. Resident #114 said her left arm pain had negatively impacted her life. She said she felt depressed and tired all the time because she did	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 13 not sleep well at night due to the pain in her left arm. She said some days she could not brush her hair or button her shirt due to the pain in her left arm. She explained that she was left handed but has had to learn to use her right arm to feed herself because her left arm was painful. Resident #114 held both of her arms straight out in front of her and made a fist with both hands. The fist on the right hand closed tightly but the fist on the left hand was not fully closed. She reported it was too painful to make a tight fist with her left hand. She said a lot of times she just dealt with the pain on her own because she felt no one had helped her. On 7/26/12 at 3:15 PM the MDS nurse was interviewed. She said she was responsible for doing the significant change MDS. She recalled that resident #114 had complained of moderate pain and had received pain medication. The MDS nurse said resident #114 should have had a care plan for pain.	F 279		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interviews with resident and staff, and record reviews the facility failed to	F 309		

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
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 309	Continued From page 14 assess a dialysis access site after a procedure and failed to assess continued complaints of left arm pain for 1 of 1 sampled dialysis resident (resident #114). Findings include: Resident #114 was admitted to the facility 4/25/12 and readmitted 5/25/12. Her diagnoses included end stage renal disease. The minimum data set (MDS) assessment dated 6/2/12 revealed resident #114 was cognitively intact. She was not coded for impairment for daily decision making. She required limited one person assistance for bed mobility, transfers, walking, dressing, toilet use, bathing and personal hygiene. She required set up help only for locomotion on the unit and eating. She was not coded for pain or dialysis. A hospital consultation note dated 5/17/12 revealed resident #114 had an arteriovenous (AV) fistula (a surgical connection of an artery and vein for dialysis) placed in her left arm on 3/5/12 due to stage four chronic kidney disease. When she was admitted to the hospital on 5/6/12 her chronic kidney disease had progressed into end stage renal disease and hemodialysis was recommended. The fistula in her left upper arm had not matured for use so a catheter was inserted in her chest for dialysis. Resident #114 was discharged to the facility on 5/25/12 with orders for dialysis three times a week. A physician's order dated 5/25/12 read; Tylenol 650 milligrams (mg) by mouth every six hours as needed.	F 309	**F309** Resident #114 was reassessed for pain by the DON and MD was notified of findings. (7/26/12) The shunt site for resident #114 was reassessed by the Unit Coordinator and findings reported to the MD. (7/26/12). All residents with physician's orders for dialysis were identified as having a shunt site by the DON. Two other residents were identified. The shunt site of the 2 identified residents was re-assessed by the Unit Coordinator. No negative findings were noted. All 3 resident will shunt sites will be assessed daily for bruit and thrill by the charge nurse. Findings will be documented on the MAR daily by the charge nurse. (7/27/12) Resident #114 was reassessed by the PA for pain and effectiveness of pain medication. (7/27/12) Resident was ordered an additional PRN dose of pain medication.	7/26/12 7/26/12 7/27/12 7/30/12 7/2712 7/27/12 7/26/12

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
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 309	Continued From page 15 A significant change MDS assessment was completed on 6/1/12 and resident #114 remained coded as cognitively intact. She required extensive one person assistance for bed mobility, dressing, bathing and personal hygiene. She required one person limited assistance for transfers, walking, locomotion on the unit, eating and toileting. She was coded to use pain medications as needed and to have moderate, occasional pain. She was also coded for dialysis. The care plan for resident #114 dated 6/4/12 identified the following; "I require renal dialysis." The goal read; I will suffer no complications due to dialysis through 9/2/12. Interventions included; "Monitor my shunt for patency, thrill (a vibration that is felt over an artery and caused by turbulent blood flow), bruit (the sound blood makes as it moves through arteries)." A physician's order dated 6/6/12 indicated resident #114 was scheduled to have a fistulogram (an X-ray taken of a fistula after a contrast medium has been injected) of her left arm AV fistula on 6/6/12. A hospital procedure note for resident #114 dated 6/6/12 revealed the left arteriovenous fistulogram demonstrated a moderate degree of stenosis (abnormal narrowing) in the proximal portion of the left upper extremity possibly resulting in the lack of thrill. Balloon angioplasty was performed and there was good result with only minimal residual narrowing. Good flow was seen throughout the entire graft with no focal narrowing or blockage. Resident #114 was discharged back to the facility on 6/6/12. The procedure discharge	F 309	Licensed nursing staff was in-serviced on the PRN policy by the DON and RN supervisor of medications and MD notification. (7/28/12, 8/15/12) Care plan conference was held with resident #114 and family to discuss plan of care with emphasis on Pain management and ADL care. Meeting conducted by Interdisciplinary Team on 8/14/12. Licensed nursing staff was in-serviced on the notification to MD of significant changes by the RN supervisors and DON. Licensed nurses were in-serviced on the Dialysis Policy and the procedure for assessing bruit and thrill by the DON. Licensed nurses will be in-serviced upon hire and annually thereafter on the Dialysis Policy and the procedure for checking bruit and thrill by the DON and/RN designee. Licensed nurses not in-serviced by the completion date for in-service on Dialysis Policy and checking of bruit and thrill by the DON/RN designee prior to next scheduled working day. 100 % audit will be conducted on residents with a shunt site will be conducted by the DON weekly x4, then monthly thereafter. Findings will be taken to the QA committee by the DON monthly x3, then quarterly x2, then as needing. Any negative findings will be reviewed by the QA committee and changes will be made to the plan as indicated by the QA Committee. Staff will be re-in serviced by DON or designee as needed.	8/15/12 8/14/12 8/15/12 8/15/12 8/16/12 8/16/12 8/17/12 8/20/12

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
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 309	Continued From page 16 instructions read; "Left arm restriction; No tight clothing, blood pressure or needle sticks in left arm. Report or call for bleeding, swelling or severe pain in left arm." A nurse's note dated 6/6/12 indicated resident #114 returned from her procedure with the bandage on her left upper arm dry and intact, with no complaints of pain, and no swelling noted. A nurse's note on 6/7/12 read; "resident states left arm tender to touch." There were no assessments documented of resident #114's left arm or left AV fistula site on 6/7/12, 6/8/12 or 6/9/12. A nurse's note on 6/10/12 read; "shunt bruted thrill to touch." A nurse's note on 6/13/12 indicated resident #114 complained of "left arm site pain" and she was medicated with Tylenol. A nurse's note on 6/15/12 revealed resident #114 complained of pain in her "left arm fistula site but not severe" and she was medicated with Tylenol. A nurse's note on 6/18/12 revealed resident #114 was medicated with Tylenol for complaints of left arm soreness. A nurse's note on 6/20/12 indicated resident #114 was medicated with Tylenol for complaints of left arm pain. A dialysis note from the nephrologists dated 6/20/12 indicated the left arm AV fistula was not	F 309		

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
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 309	Continued From page 17 developing well and resident #114 may be referred back to the surgeon. There were no assessments documented of resident #114's left arm or left AV fistula site from 6/11/12 through 6/20/12. A nurse's note on 6/21/12 read; "Permacath site and fistula site in left arm are both good no bleeding noted." A nurse's note dated 6/22/12 indicated resident #114 complained of left arm pain and was medicated with Tylenol. There were no assessments documented of resident #114's left arm or left AV fistula site on 6/22/12, 6/23/12 or 6/24/12. A nurse's note on 6/25/12 indicated the left AV fistula site was; "clear with no bleeding noted." A dialysis note on 6/27/12 from the nurse practitioner at the dialysis center read; "Will have patient scheduled to see (surgeon) due to pain in left AVF since angiogram and no thrill or bruit noted during rounds." A nurse's note on 6/29/12 read; "resident went to dialysis today came at 530pm with order to go see (physician) d/t (due to) c/o (complaints of) pain in Lt (left) arm access Monday July 2, 2012." There were no assessments documented of resident #114's left arm or left AV fistula site from 6/26/12 through 6/30/12. Review of the June 2012 medication	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 309	Continued From page 18 administration record (MAR) revealed resident #114 received Tylenol 650 mg once a day on 6/11/12, 6/18/12, 6/20/12, 6/21/12, 6/22/12, 6/25/12, 6/26/12, 6/28/12 and 6/30/12. She received Tylenol 650 mg twice a day on 6/12/12, 6/13/12, 6/15/12 and 6/19/12. There were no assessments of resident #114's pain level in the June 2012 nurse's notes or on the June 2012 MAR. Review of the "Dialysis Visit Findings and Orders" communication sheets for June 2012 revealed no concerns of left AV fistula pain or left arm pain discussed between the facility and the dialysis center. A physician's progress note from the surgeon's assistant dated 7/2/12 revealed resident #114's left AV fistula was "not working," there was no bruit or thrill. She planned to discuss the findings with the surgeon for a possible procedure to declot (remove the clot in) the AV fistula. A nurse's note dated 7/2/12 indicated that resident #114 had returned from her doctor's appointment and quoted the physician assistant's note that the fistula was not working and there was no bruit or thrill. A nurse's note dated 7/6/12 indicated the resident was medicated for complaints of AV fistula site pain. Nurse's notes on 7/11/12 and 7/13/12 revealed resident #114 was medicated with Tylenol for left arm pain.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 309	Continued From page 19 A nurse's note on 7/20/12 indicated resident #114 was medicated for left hand and left arm pain. There were no assessments documented of resident #114's left arm or left AV fistula site in July 2012. Review of the July 2012 medication administration record (MAR) revealed resident #114 received Tylenol 650 mg once a day on 7/2/12, 7/3/12, 7/5/12, 7/6/12, 7/10/12, 7/14/12, 7/15/12, 7/16/12, 7/17/12, 7/23/12 and 7/25/12. She received Tylenol 650 mg twice a day on 7/9/12, 7/11/12, 7/12/12, 7/13/12, 7/18/12, 7/19/12, 7/20/12, 7/24/12 and 7/26/12. The national Institute of Health numerical pain scale classified pain from 4-6 as moderate and 7-10 as severe. Review of the July 2012 MAR revealed resident #114 complained of severe pain on 7/16/12 and 7/17/12 and moderate pain on 7/9/12, 7/10/12, 7/11/12, 7/12/12, 7/18/12, 7/19/12, 7/20/12, 7/24/12, 7/25/12 and 7/26/12. Pain was not assessed and the site of the pain was not documented every time Tylenol was administered. Review of the "Dialysis Visit Findings and Orders" communication sheets for July 2012 revealed no concerns of left AV fistula pain or left arm pain discussed between the facility and the dialysis center. On 7/24/12 at 2:20 PM resident #114 was observed in bed in her room. She frowned as she rubbed her left arm and shoulder. She said her left arm had hurt since early June when she had a procedure on her AV fistula. She indicated she	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 309	Continued From page 20 received Tylenol for pain almost every day but it did not help much. On 7/25/12 at 4:30 PM the dialysis center nurse was interviewed. She indicated resident #114 received dialysis through a catheter in her chest and the AV fistula in her left arm was not used for dialysis. The nurse reported that resident #114 had complained of left arm pain on several occasions and she (the nurse) had reported the left arm pain to the nurse practitioner at the dialysis center but could not recall when she reported the pain. The dialysis center nurse said the left AV fistula was assessed each time she was at dialysis but she could not recall when the AV fistula was found to be without a bruit or thrill. The nurse reported that the resident had an appointment scheduled July 30, 2012 with the surgeon for the left AV fistula. The dialysis nurse indicated that resident #114 received Tylenol for her left arm discomfort and reported to the staff at the dialysis center that the Tylenol was effective. She said the facility and the dialysis center communicated by the written "Dialysis Visit Findings & Orders" sheet and by phone. She could not recall specifically any concerns she had called to the facility for resident #114. On 7/25/12 at 4:45 PM the nurse practitioner (NP) at the dialysis center was interviewed. She reported that she made rounds weekly and assessed the AV fistula site for resident #114. She said resident #114 had complained of pain in her left arm since she had the balloon angioplasty procedure in early June. The NP reviewed her notes and indicated on 6/7/12 following the fistulogram there was a faint bruit and thrill at her left AV fistula site. She noted that on 6/28/12,	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 309	Continued From page 21 there was no bruit or thrill. She would have the resident see the surgeon for follow up. The NP said resident #114 was scheduled to see the surgeon on July 30, 2012. On 7/26/12 at 8:50 AM the resident was interviewed. She stated her left arm had hurt from her shoulder to her fingertips daily since the AV fistula procedure in early June. She described her pain as "excruciating" at times and said she could only take Tylenol for the pain due to her heart. She indicated that Tylenol helped temporarily. Resident #114 said her left arm pain had negatively impacted her life. She said she felt depressed and tired all the time because she did not sleep well at night due to the pain in her left arm. She said some days she could not brush her hair or button her shirt due to the pain in her left arm. She explained that she was left handed but has had to learn to use her right arm to feed herself because her left arm was painful. Resident #114 held both of her arms straight out in front of her and made a fist with both hands. The fist on the right hand closed tightly but the fist on the left hand was not fully closed. She reported it was too painful to make a tight fist with her left hand. Resident #114 said no one at the facility had palpated her left arm to assess for a thrill or listened to her fistula to assess for a bruit even after she complained of pain and asked for Tylenol. She said she could not recall that any nurse had asked her to rate her pain prior to Tylenol or after to see if it had helped. She said a lot of times she just dealt with the pain on her own because she felt no one had helped her. On 7/26/12 at 10:37 AM nurse #1 was interviewed. She indicated that resident #114	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 309	Continued From page 22 was alert and oriented and cognitively intact. When asked about the resident's left arm pain she stated "something was done to her left arm, was not sure what had been done." Nurse #1 said when the resident had complained of left arm pain she had only "looked" at the left arm but did not look at it every time and she had never palpated or listened to the left arm AV fistula. She indicated the facility communicated with the dialysis center via paper sheet and via phone but was not aware of any concerns with the AV fistula. She said resident #114 had received Tylenol for pain almost daily but she had never called the physician. She said she had reported the resident's left arm pain to the unit supervisor but could not recall when she reported it. Nurse #1 said she had never assessed the left AV fistula for bruit or thrill because someone had told her it didn't work. Nurse #1 could not recall who had told her the AV fistula did not work or when they had told her. Nurse #1 said she was not aware of resident #114 being unable to perform tasks with her left hand. On 7/26/12 at 11:56 AM nurse #2 was interviewed. She said she worked second shift and was often the nurse who received resident #114 back from dialysis. She said the resident received dialysis through her chest site. When asked about resident #114's left arm pain, nurse #2 said the resident usually complained of pain around a level 8 and she had assessed the resident's left AV fistula each day she had worked with her and could "feel a thrill but there had not been a bruit." Nurse #2 said she was not sure why she had not documented her abnormal findings. When nurse #2 was read the NP note from 6/28/12 that there was no thrill or bruit she	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 309	Continued From page 23 said she had never felt a bruit or thrill in the AV fistula and could not explain why she had not documented the abnormal findings. She said she did not notify the physician because he was already aware of the resident's left arm pain and that the fistula was not working. Nurse #2 also stated "last week" resident #114 complained of left hand numbness and said she did not notify the physician. Nurse #2 could not explain why she did not document the left hand numbness or notify the physician or why she did not document any of her assessments of resident #114's left arm. On 7/26/12 at 12:25 PM nurse #3 was interviewed. She said she worked weekend days with resident #114. She said the resident occasionally complained of left arm pain and that she assessed the left arm AV fistula each time she worked with the resident. She said she last assessed the AV fistula "this past weekend" (July 21 and 22) and the fistula was "normal." When Nurse #3 was read the NP note from 6/28/12 that there was no thrill or bruit she said that she "may have gotten busy last weekend and not assessed the AV fistula." Nurse #3 could not explain why she did not document any of her assessments. On 7/26/12 at 1:05 PM the unit supervisor was interviewed. She said her expectation was that an active dialysis access be assessed daily and or before and after dialysis for bleeding, signs of infection, bruit and thrill. She said she expected a non-active site to be assessed weekly. If a site had a recent procedure or a resident complained of pain in a limb with a dialysis access she expected the site to be assessed daily and at each complaint of pain. The unit supervisor also	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 309	Continued From page 24 expected the staff to document the assessment. On 7/26/12 at 2:40 PM the Director of Nursing (DON) was interviewed. She said she expected staff to assess an AV fistula daily. If the site had a recent procedure she expected the AV fistula to be assessed every shift. The DON also indicated she expected the staff to document the assessment. The DON stated the facility did not have a policy or procedure for dialysis residents or the assessment of dialysis access sites. On 7/26/12 at 3:11 PM resident #114 was observed in activites. She used her right arm and hand to perform the activity. On 7/26/12 at 3:45 PM the certified occupational therapy assistant (COTA) was interviewed. She recalled that resident #114 complained of left arm pain and the pain did impair her ability to dress herself and brush her hair with her left arm at times. The COTA indicated she told the nurse however she did not document it and could not recall who she told or the date resident #114 had complained. On 7/26/12 at 6:19 PM resident #114 was observed in bed in her room. She used her right arm to hold a news paper, her left arm was folded across her abdomen. On 7/27/12 at 11:10 AM the facility physician was interviewed. He said he could not recall or find documentation that anyone from the facility had notified him of resident #114's left arm pain. He indicated that resident #114 should have had an order written to assess the left arm AV fistula and the order should have included the frequency of	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 309	Continued From page 25 the assessment. The facility physician said he expected the facility to have a procedure in place for assessment of dialysis access sites. He said he expected that residents #114's left arm would have been assessed for each complaint of pain. Unsuccessful attempts were made to contact the surgeon and the nephrologists for interview.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING 03 - MAIN BUILDING B. WING	08/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 New 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	Haymount Rehabilitation and Nursing 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 the plan of correction does not denote agreement with the citation by Haymount Rehabilitation and Nursing 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.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.2.5.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 8/21/12 at approximately 1:30 PM the following was noted: 1) There are two large holes and a smaller hole in the top layer of sheetrock in the attic area located above the kitchen. 42 CFR 483.70	K 012	**K012** 1. The two large holes and a smaller hole in the top layer of sheetrock in the attic above the kitchen were patched by the Maintenance Director.	9/14/12
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl M. Goodie — TITLE: Administrator — (X6) DATE: 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.

021070

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
	345414	A. BUILDING 03 - MAIN BUILDING B. WING _____	08/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2345 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 8/21/12 at approximately 1:30 PM the following was noted: 1) The corridor doors to the soiled linen, norishment and clean linen rooms located at the Long Term nursing station did not close, latch and seal. 42 CFR 483.70	K 029	**.K012 cont.** 2. The total attic area was inspected to ensure that no other non-compliance issues were present. 3. The Maintenance Director will inspect the total attic area for holes and will fix as necessary. Contractors performing work in the attic area will be advised to correct/report any holes that are created from their work. 4. The Maintenance Director or designee will complete a monthly inspection of the attic area for three months and then quarterly thereafter. Findings will be discussed by the Safety Committee monthly. Facility protocols and/or in-servicing will be adjusted accordingly.	8/21/12 9/17/12 9/25/12
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation on Tuesday 8/21/12 at approximately 1:30 PM the following was noted: 1) Upon review of Fire Alarm inspection report dated 7/10/12 from VSC Fire and Sprinkler Inc., there are deficiencies noted in the report that were not corrected: a. Smoke detector outside therapy did not operate. b. Smoke detector needed to be cleaned. 42 CFR 483.70	K 052	**K029** 1. The corridor doors to the soiled linen, nourishment, and clean linen located at the LT nursing station were adjusted by the Maintenance Director. 2. All corridor doors have been inspected by the Maintenance Director to ensure proper closure and sealing.	9/12/12
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance	K 069		8/28/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING 03 - MAIN BUILDING B. WING _____	08/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 069	Continued From page 2 with 9.2.3. 18.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation on Tuesday 8/21/12 at approximately 1:30 PM the following was noted: 1) The kitchen makeup air for the kitchen hood was not sufficient at the time of survey. The kitchen was experiencing a negative air balance at the time of the survey. 42 CFR 483.70	K 069	**K029 cont.** 3. Staff will be in-serviced to notify the Maintenance Director of doors that do not close and seal properly so that the doors can be corrected. 4. The Maintenance Director or designee will complete a monthly inspection of all corridor doors. Findings will be discussed by the Safety Committee monthly. Facility protocols and/or in-servicing will be adjusted accordingly.	9/17/12 9/25/12
K 104 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation on Tuesday 8/21/12 at approximately 1:30 PM the following was noted: 1) The two smoke dampers located above the kitchen did not operate when tested. 42 CFR 483.70	K 104	**K052** 1. Maintenance Director was already aware of the non-functioning smoke detector. The smoke detector is scheduled to be replaced by 9/14/12. 2. All smoke detectors will be inspected by a contractor service to ensure they work properly and are clean. Any deficiencies found will be corrected by the contractor service or Maintenance Director. 3. Maintenance Director will randomly check smoke detectors during the two monthly fire drills. Contractor service will continue to inspect smoke detectors on an annual basis to ensure they work properly and are clean.	9/14/12 9/14/12 9/17/12

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
	345414	A. BUILDING 03 - MAIN BUILDING B. WING _____	08/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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
			K052 cont. 4. Monthly checks and annual inspections will be discussed by the Safety Committee monthly. Facility protocols and/or in-servicing will be adjusted accordingly.	9/25/12
			K069 1. The kitchen makeup air for the kitchen hood system was inspected by a contractor service.	9/17/12
			2. Maintenance Director will inspect the hood system to ensure proper functioning weekly for 4 weeks and then monthly thereafter.	9/17/12
			3. Inspections will be discussed by the Safety Committee monthly. Facility protocols and/or in-servicing will be adjusted accordingly.	9/25/12
			K104 1. The two smoke dampers located above the kitchen are scheduled to be repaired by 9/14/12.	9/14/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING 03 - MAIN BUILDING B. WING _____	08/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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
			K104 cont 2. All smoke dampers will be inspected by a contractor service to ensure they work properly and are clean. Any deficiencies found will be corrected by the contractor service or Maintenance Director.	9/14/12
			3. Maintenance Director will randomly check smoke dampers during the two monthly fire drills. Contractor service will continue to inspect smoke dampers on an annual basis to ensure they work properly.	9/17/12
			4. Monthly checks and annual inspections will be discussed by the Safety Committee monthly. Facility protocols and/or in-servicing will be adjusted accordingly.	9/25/12