STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345170	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 9/7/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL BLUFFS REHABILITATION AND HEALTI	4010 BRIDGES STREET EXTENSION MOREHEAD CITY, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice(if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing

The facility must inform each resident who is entitled to Medicaid benefits in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part489 of this chapter related to maintaining written policies and procedures regarding advance directives These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible

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 disclosable90 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 disclosable14 days following the date these documents are made available to the facility If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345170	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 9/7/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL BLUFFS REHABILITATION AND HEALTI	4010 BRIDGES STREET EXTENSION MOREHEAD CITY, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 1

for his or her care.

The facility must prominently display in the facility written information and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to provide required liability and appeal notices for two of three sampled residents (residents #113 and #163).

Findings include:
1. Resident # 113 was admitted on 3/26/12. The facility was not able to provide documentation that Resident #113 received an approved Notice of Medicare non-coverage letter that notified him Medicare services were ending, and his right to appeal. The resident ' s Medicare benefits ended on 4/12/2012.

In an interview on 9/6/12 at 11:50 AM, the business office manager stated that she came to work there in April, 2012. She stated that she found that the Medicare letters regarding liability had not been sent to two of the three residents that she reviewed.

In an interview on 9/6/2012 at 2:30 PM, the administrator stated that her expectation was that the liability notices would be sent to all residents whose benefits were going to expire

2. Resident # 163 was admitted to the facility on 3/5/12. The facility was not able to provide documentation that Resident #163 received an approved Notice of Medicare non-coverage letter that notified him Medicare services were ending, and his right to appeal. The resident 's Medicare benefits ended 3/27/12.

In an interview on 9/6/12 at 11:50 AM, the business office manager stated that she came to work there in April, 2012. She stated that she found that the Medicare letters regarding liability had not been sent to two of the three residents that she reviewed.

In an interview on 9/6/2012 at 2:30 PM, the administrator stated that her expectation was that the liability notices would be sent to all residents whose benefits were going to expire

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
	345170	A. BUILDING 02 - CRYSTAL BLUFFS B. WING _____	10/10/2012

RECEIVED
OCT 29 2012
CONSTRUCTION SECTION

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL BLUFFS REHABILITATION AND HEALTH CARE CENT	4010 BRIDGES STREET EXTENSION MOREHEAD CITY, NC 28557

(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 Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the New Health Care section of the LSC and its referenced publications. This building is Type II (211) construction, one story, with a complete automatic sprinkler system. Facility is using NCSBC special locking system. The deficiencies determined during the survey are as follows:	K 000	Preparation and submission of this Plan of Correction is in response to the HCFA Form 2567. It does not constitute an agreement or admission by Crystal Bluffs Rehabilitation and Health Care Center of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiency. The facility reserves the rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction also functions as the facility's credible allegation of compliance.	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	K 027	(1) Adjusted latching arm on corridor and resident doors to complete repair. (2) An audit for all corridor and resident doors was completed. (3) Maintenance Director will complete weekly audits to ensure deficient practice will not recure.	10.15.12 10.15.12 10.15.12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] LNHA	ADMINISTRATOR	10.19.12

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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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
	345170	A. BUILDING 02 - CRYSTAL BLUFFS B. WING _____	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL BLUFFS REHABILITATION AND HEALTH CARE CENT	4010 BRIDGES STREET EXTENSION MOREHEAD CITY, NC 28557

(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 027	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncomplaint: specific findings include: cross corridor doors on 200 hall(right side coming out of 200 hall) did not close and latch for smoke tight seal. 42 CFR 483.70(a)	K 027	(4) Maintenance Director will bring the monitoring process to daily meeting five (5) times per week for two (2) weeks and then weekly for six (6) weeks. Monitoring process will then be forwarded to QA committee for compliance. The QA committee will review and record plan in meeting minutes with compliance or non-compliance noted and revise process as needed.	10.19.12
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncomplaint: specific findings	K 051	(1) All audio and visual linked to alarm system was checked was telecommunication company (2) Telecommunication set up controls so that both visual and audio alarm is present when there is a loss of phone lines. (3) Maintenance Department will complete weekly audits to ensure the deficient practice will not recur. (4) Maintenance Director will bring the monitoring process to daily meeting five (5) times per week for two (2) weeks and then weekly for six (6) weeks.	10.19.12 10.19.12 10.19.12 10.19.12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 051	Continued From page 2 include: with loss of telephone connection, there was no audible/visual signal at Fire Alarm Control Panel at either nurse station. 42 CFR 483.70(a)	K 051	Monitoring process will then be forwarded to QA committee for compliance. The QA committee will review and record plan in meeting minutes with compliance or non-compliance noted and revise process as needed.	
K 067 SS=E	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. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncomplaint: specific findings include: HVAC system on Sound side did not shut down on activation of fire alarm. 42 483.70(a)	K 067	(1) Telecommunications checked fire alarm system. (2)Telecommunications set up controls at the fire panel to shut down HVAC when a fire alarm goes off. (3) Maintenance Director will complete weekly audits to ensure that deficient practice will not recur. (4) Maintenance Director will bring the monitoring process to daily meeting five (5) times per week for two (2) weeks and then weekly for six (6) weeks. Monitoring process will then be forwarded to QA committee for compliance. The QA committee will review and record plan in meeting minutes with compliance or non-compliance noted and revise process as needed.	10.19.12 10.19.12 10.19.12 10.19.12