Received 1/4/13

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 000	INITIAL COMMENTS The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section conducted a recertification and complaint investigation survey on November 27, 2012 through November 30, 2012. It was determined the facility had provided substandard quality of care at the Immediate Jeopardy level at F323J. The facility was notified of the Immediate Jeopardy at F323 on November 29, 2012. An extended survey was conducted on November 30, 2012. The facility provided a credible allegation on November 30, 2012 and an exit conference was held with the facility on November 30, 2012. No deficiencies were cited as a result of the complaint investigation. Event ID ZTIJ11.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to keep resident room and bathroom doors, resident room and bathroom walls, resident furnishings, and window blinds in good repair for 11 of 34 rooms (Rooms 107, 201, 202, 207, 208, 209, 210, 211, 212, 302, and 308). The following observations were observed on 11/27/12:	F 253	F253 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s), and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature], RN	Administrator	12/21/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 253	Continued From page 1 During an observation of room 107 on 11/27/12 at 3:01pm it was noted that the bedside table for Bed B had several pieces of peeling and missing veneer on the top of the bedside table as well as on the front of the drawers. The blinds were also noted to have bent slats on the right side of the window blind. There were no changes in the observations throughout the survey dates. During an observation of room 202 on 11/27/12 at 11:37am it was noted that the bathroom door had pieces of wood that were chipped, rough and splintered. The bottom half of the resident ' s room door was also noted to be scratched and marred.There were no changes in the observations throughout the survey dates. An observation was made of room 207 on 11/27/12 at 11:16am revealed a high back white armchair with all four legs scratched and marred in multiple places. There were no changes in the observations throughout the survey dates. During an observation of room 208 on 11/27/12 at 10:47am it was noted that the white high back arm chair with all four legs scratched and marred in multiple places. There were no changes in the observations throughout the survey dates. During an observation of room 302 on 11/27/12 at 10:42 revealed the bathroom walls under the soap dispenser, the wall surrounding the sink, and the wall behind the commode was stained with light green streaks. There were no changes in the observations throughout the survey dates. An observation was made of room 210 on	F 253	Room 107: A new bedside table has been provided for Bed B. A new window blind has been provided for the window. Room 202: The bathroom door has been repaired accordingly. Room 207: The high back chair in the room has been repaired accordingly. Room 208: The high back chair in the room has been repaired accordingly. Room 302: The bathroom wall has been repaired accordingly.	01/13/13 01/13/13 01/13/13 01/13/13 01/13/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 253	Continued From page 2 11/27/12 at 11:08am revealed the bottom of the resident ' s room door was scratched and marred, the bedside table beside Bed A had pieces of peeling and missing veneer, and there was a piece of crown molding (approximately 6 feet) missing from the ceiling on the wall beside bed A where the cubicle curtain hardware and been moved. There were no changes in the observations throughout the survey dates. During an observation of room 211 on 11/27/12 at 3:14pm it was noted the bathroom door was marred and had multiple scratches on the bottom half of the door. There were no changes in the observations throughout the survey dates. On 11/28/12 the following observations were made: An observation of room 212 on 11/28/12 at 9:27am revealed the resident ' s room door was scratched and marred and a piece of crown molding (approximately 6 feet) was missing from the ceiling on the wall beside bed A where the cubicle curtain hardware had been moved. There were no changes in the observations throughout the survey dates. An observation was made of Room 201 on 11/28/12 at 9:54am which revealed the bathroom wall had pieces of sheetrock peeling and paint cracking on the left side of the sink. There were no changes in the observations throughout the survey dates. An observation of room 209 on 11/28/12 at 10:18am revealed the bathroom door had some chipped pieces of wood on the edges of the	F 253	F253 Room 210: The door has been repaired accordingly. A new bedside table has been provided for Bed A. The crown molding on the wall beside of Bed A has been replaced. Room 211: The bathroom door has been repaired accordingly. Room 212: The door to the resident's room has been repaired accordingly. The crown molding on the wall beside of Bed A has been replaced. Room 201: The bathroom wall has been repaired accordingly. Room 209: The bathroom door has been repaired accordingly.	01/13/13 01/13/13 01/13/13 01/13/13 01/13/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 253	Continued From page 3 door and were noted to be rough. The bottom of the bathroom door was also noted to be scratched and marred. There were no changes in the observations throughout the survey dates. An observation of room 308 11/28/12 at 11:21am revealed peeling paint and scratched sheetrock on the wall on the left side of entrance into the room, a vent with scratched paint and bent slats on same wall and peeling paint above the closet. The resident ' s door was also noted to be scratched and marred. There were no changes in the observations throughout the survey dates. On 11/30/12 at 2:00pm observations were made with the Maintenance Director of all the above listed rooms as well as an interview with the maintenance director was conducted. All the same observations were made. The maintenance director stated the staff verbally reports items in need of repair to him on a daily basis. He indicated there is no formal system of staff writing down concerns/problems, of documentation of when a repair is made or any type of documentation that maintenance makes rounds for general maintenance and repair on a scheduled basis. During an interview with the facility administrator on 11/30/12 at 4:30pm, the administrator indicated that the identified areas in need of repair would be repaired and the chairs and bed side tables would be replaced.	F 253	Room 308: All areas on walls have been repaired, the vent has been removed and wall repaired with sheetrock. The door has been repaired accordingly. For those resident's having the potential to be affected by the same alleged deficient practice, all resident rooms have been checked for needed repairs by the maintenance staff and will be repaired accordingly. The staff has been in-serviced on the proper use of the "Maintenance Work Order" form and how to report repair and environmental issues to the Maintenance Director. Upon receipt of the work orders, the facility administrator shall verify the completion of of work and initial the form. The Plan of Correction for this alleged deficient practice has been incorporated into the facility's most recent Quality Assurance Committee meeting minutes and shall be evaluated for effectiveness no less than monthly for three months and quarterly thereafter on a continuing basis.	01/13/13 01/13/13
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 280	Continued From page 4 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to revise and update the care plan for 1 of 4 residents (resident #49) after the resident had experienced four falls. Resident # 49 was admitted to the facility on 05/20/2009. His most recent MDS had an assessment referenced date of 10/15/12 and had documentation that the resident had been assessed as being alert and oriented with a BIMS score of 15, as being independent with his Activities of Daily Living and as being not steady with his balance but able to stabilize himself without assistance. His diagnoses were listed as status post Bilateral Lower Extremity Amputation, Hypertension, Diabetes Mellitus and Congestive	F 280	F280 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid Program(s), and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). Resident #49's care plan has been updated to include his recent fall and non-compliant behavior(s).	11/30/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 280	Continued From page 5 Heart Failure. Review of resident #49's medical record revealed a nursing note dated 7/30/12 at 8:30am which read in part: Resident was found sitting on floor at 8:00am. Resident stated "he dozed off and fell on the floor." He said he "hit his head". No notable injuries at this time. Resident denies any pain or other needs. Resident has been asked several times to lie in bed when sleepy. He is non-compliant regarding these requests. Another nursing note was written on 9/13/12 at 4:30am which read in part: Resident noted on the floor beside the wheelchair asleep. When asked how he got on the floor, resident laughed. No bruising noted. No complaint of pain. Resident transferred via Hoyer lift per three staff to motorized chair. No distress noted. No treatment needed. A nursing note was written on 10/7/12 at 8pm that stated resident was found sleeping on the floor in front of his wheelchair. Resident refused to let staff help him in his wheelchair. He asked staff for two pillows. Resident got self back in his wheelchair. Staff stayed with resident until resident was secure in his chair. Another nursing note was written on 11/24/12 at 5:45pm which read in part: Called to resident's room. Resident was on the floor in front of his wheelchair facing the wheelchair and stated he fell. He complained of Left Stump pain. An order was given to send resident to the emergency room for evaluation. Review of facility incident reports had documentation of resident having fallen on	F 280	For those resident's having the potential to be affected by the same alleged deficient practice, the MDS Coordinator has reviewed the care plans of each resident that were care planned for falls; to ensure the interventions/approaches are updated for each fall if indicated. To complete this task, the MDS Coordinator shall reconcile the care plans of all residents currently care planned for falls against the facility's incident (falls) log for the most recent three months. Any resident's care plan found to be lacking an update related to the interventions subsequent to a fall; shall be updated to include the new interventions/ approaches related to falls. The nurse's have been educated on the need to provide a copy of any incident report to the MDS Coordinator, Director of Nurses,and the Administrator. Additionally, the MDS Coordinator was made aware on November 30, 2012, of the importance of updating the care plans by revising any interventions /approaches related to falls.	01/13/ 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 280	Continued From page 6 7/30/12, 9/13/12, 10/8/12, and 11/24/12. Review of the resident ' s care plan revealed a care plan related to falls with an onset date listed as 3/7/12. The problem was listed as impaired mobility/transfers (bilateral lower extremity amputee). The goal was written as resident will transfer from bed to chair and sit to stand with stand by assist. The interventions were listed as PT (Physical therapy) 5 times a week for therapeutic exercise, gait training, transfers and prosthetic training, OT (Occupational Therapy) 5 times a week for therapeutic exercise, transfers, prosthetic training and safety, assess and document resident ' s motor strength, joint range and balance, evaluate the use of assistive devices for transferring from bed to chair with prosthetic legs, if assistive devices are used, educate resident on how to use, and allow resident the opportunity to perform task themselves prior to offering assistance. The interventions had a line drawn diagonally through them and a hand written note under the problem that read " Dc ' d (MDS nurse name), RN " . There was no date to indicate when the hand written note was placed on the care plan. The care plan had a problem listed as Impaired thought processes/hallucinations and delusions of worms coming out of his skin. The problem onset date was 7/16/12. The goal was written as Resident will be free of injury over the next ninety days. The interventions were listed as resident will be evaluated by a neurologist and dermatologist, lab work will be obtained to evaluate kidney and liver function, reassure resident when he complains of the " worms crawling out of his skin. " , calmly talk with	F 280	The MDS Coordinator shall monitor for compliance by auditing 25% of resident's MDS' monthly for three months and quarterly using the facility's incident (falls) report logs, documenting on the Care Plan / Falls Audit tool. The Director of Nursing and the Administrator will monitor care plans and the Care Plan / Falls Audit tool monthly for three months and quarterly thereafter to ensure care plans are being updated accordingly. The MDS Coordinator shall present the findings and subsequent plan of correction for this alleged deficient practice to the facility's Quality Assurance Committee. Futhermore, the MDS Coordinator shall report to the committee any identified discrepancies no less than monthly for three months, and quarterly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 280	Continued From page 7 resident and offer reassurance prior to initiating care, keep resident environment free of clutter and safety hazards, call light in reach at all times in room and bathroom, instruct the resident on use of call bell and reinforce the need for use with each contact, monitor and document resident behavior and status at least daily, and report any change in cognitive status to physician. There were no notes written nor was the care plan revised or updated since the onset date. The back sheet of the care plan was signed by the MDS nurse, the social worker, the activities director and dated for 7/16/16. There was a care plan with the problem onset date of 1/31/11 with the problem listed as Resident is at risk for falls due to mind altering drugs. On the care plan under the problem there was a hand note written that read, " Revised 10/8/12. See next page. " , and was signed by the MDS nurse. The care plan on the next page had the problem onset date listed as 10/8/12. The problem was bilateral lower extremity amputee, obese/narcolepsy, recent fall. The goal was written as resident will not experience any injuries related to fall. The interventions were listed as: transfer board for transfers, check on resident frequently in shower room, call bell in reach at all times, monitor for changes in resident ' s condition that may warrant increased supervision/assistance and notify the physician, wheelchair alarm to motorized wheelchair, monitor for adverse reactions to antidepressants, pain, amphetamines, amphetamine salts 10	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 280	Continued From page 8 milligrams three times a day, lyrica 300 milligrams by mouth twice a day at 4:00pm and 8:00pm. The back page of the care plan had handwritten notes which included: " #3 Recent fall 10/7/12. Care plan revised and updated. " The care plan was signed by the MDS nurse, social worker and the activities director on 10/15/12. During an interview on 11/30/12 at 3:40pm with the MDS nurse, she indicated that she is responsible for revising and updating the care plans. She further added that there is no formal written communication that she receives when a care plan needs to be updated or revised, that the nurses will tell her verbally or she will hear about it during the morning meetings. In regards to resident # 49 and his falls, she stated that after the fall on 7/30/12 a drug regimen review was done. She stated that she didn ' t revise or update the care plan after the fall. The MDS nurse stated she wasn ' t aware resident #49 fell on 9/13/12 therefore the care plan wasn ' t revised or updated after the fall. She further added after resident #49 fell on 10/7/12 a wheelchair alarm was placed on his wheelchair. She stated that she revised the care plan to include the chair alarm on 10/8/12. The MDS nurse stated that she did not revise or update the care plan after resident #49 ' s fall on 11/24/12 because she didn ' t know what else to do for him.	F 280		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 STANDARD DISCLAIMER: This Plan of Correction is a necessary requirement to participate in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility staff failed to supervise 2 of 2 sampled cognitively impaired residents assessed as being at risk for elopement (Resident #94 and Resident #76). Immediate Jeopardy began on 07/01/12 when Resident #94 left the facility unsupervised and was found by police at a grocery store. Resident #76 exited the facility and was found by the road in front of the facility on 08/09/12. Immediate Jeopardy was identified on 11/29/12 at 9:00 AM and was removed on 11/30/12 at 1:00 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D with more that minimal potential for harm that is not immediate jeopardy. The findings include: 1a. Resident #94 was originally admitted to the facility on 10/06/11 and re-admitted on 12/10/11 with diagnoses including Renal Failure, Hypertension, Presenile Dementia and Vertigo. A facility elopement risk assessment dated 04/19/12 showed that Resident #94 had a history of leaving the facility without supervision as evidenced by previous attempts. The resident ' s care plan last updated 04/19/12 showed that the resident was at risk for elopement with a goal for the resident to be	F 323	Resident #94 is no longer at the facility. Resident #94 was never harmed as a result of the alleged deficient practice. The state survey agency was provided with an acceptable credible allegation of compliance on 11/29/12. The "immediate jeopardy" alleged practice was removed the following day, 11/30/12.	11/30/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 10	F 323		

re-directed by staff before leaving the facility during elopement attempts. Interventions included: " Assign staff to account for resident ' s whereabouts at all times. Alert staff to resident ' s elopement behavior. Place resident in an area where constant observation is possible. Note which exits resident favors for elopement from facility. Alert staff working near those areas. If resident elopes from the facility, implement facility protocol for locating resident. "

The most recent Minimum Data Set (MDS) Assessment dated 10/15/12 showed that Resident #94 was severely cognitively impaired. The MDS showed that the resident was independent with wheelchair mobility and used a cane as an assistive device for walking. The MDS showed that the resident had exhibited wandering behaviors which occurred 1-3 days during the review period. The MDS showed that the resident received medications for anxiety and agitation as needed.

The elopement risk assessment dated 10/15/12 showed that the resident had a history of leaving the facility without supervision. The elopement assessment had a section for potential interventions. None of the interventions were checked.

A nurse ' s note written by Nurse #1 dated 07/01/12 at 6:45 AM read: " Rsdt (resident) not in room was last seen around 5:30 AM. Facility and grounds searched thoroughly by staff and nurse in charge, unable to locate rsdt. Rsdt ambulating on foot with cane, wheelchair in room. Called DON (Director of Nursing) and police notified. Rsdt found by police in (name of supermarket)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 11 parking lot. Staff went to pick up rsdt. Assessment upon arrival back to facility. No signs/symptoms of acute distress noted. No signs/symptoms of injury noted. " On 11/28/12 at 3:00 PM, Resident #94 was observed sitting in his wheelchair in his room next to the bed with his eyes closed. On 11/28/12 at 4:45 PM, Resident #94 was sitting in his wheelchair in his room. The resident was observed to stand up and the chair alarm sounded. Nurse #1 stated in an interview on 11/28/12 at 8:45 AM that she was working on the morning of 07/01/12. The Nurse stated that Resident #94 was confused and a lot of the time he talked about leaving the building. The Nurse stated that she was passing medications around 6:00 AM and a nursing assistant said he was not in his room. The Nurse stated that the resident ' s alarm did not sound on his wheelchair. The Nurse stated that she called the police and had staff search the building inside and outside. The Nurse stated that the resident was found at a local grocery store by the police and that Nurse #3 brought the resident back to the facility. The Nurse stated that she did not know how long the resident was gone from the facility. An interview was conducted with Nursing Assistant (NA) #1 who was assigned to Resident #94 on 07/01/12. The NA stated that the last time she saw the resident was at 5:30 AM in his room. The NA stated that Nurse #2 told her the resident was missing.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 12 Nurse #3 stated in an interview on 11/29/12 at 1:50 PM that he was on his way to work when he learned that Resident #94 was missing. The Nurse stated that Resident #94 had made attempts to leave the building but they usually would catch him before he left the parking lot. The Nurse stated that he picked up the resident at the grocery store. The Nurse stated when he brought the resident back to the building he tried to get him to calm down and he called a family member and re-oriented him back to the facility. The Nurse stated that he checked the resident for injuries and the resident was able to move all extremities. The Nurse stated that he knew that Resident #94 wandered and he was aware that staff needed to keep an eye on him, however, the resident was fast. During an interview on 11/29/12 at 3:30 PM, the Director of Nursing (DON) stated she was called on the morning Resident #94 left the facility. The DON stated that she arrived at the facility within ten minutes and helped with the search of the facility and the grounds. The DON stated that Nurse #3 picked up the resident at the grocery store and returned him to the building unharmed. The DON stated that the resident was assigned a sitter from July 1-8, 2012. The DON stated there were no revisions to the resident ' s care plan because he had already been care planned. The DON stated that she made sure that the resident was safe. The MDS Coordinator stated in an interview on 11/29/12 at 4:35 PM that everyone in the building was aware of the resident ' s wandering behaviors.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 13 On 11/30/12 at 3:30 PM the mileage from the facility to the grocery store was observed to be three tenths of a mile or 1584 feet. There were 3 traffic lanes in front of the facility and at the end of the street the resident would have to cross 5 traffic lanes to reach the grocery store where he was found. 1b. A nurse ' s note written by Nurse #4 dated 10/14/12 at 5:15 PM read: " Resident out of facility in wheelchair attempting to leave out of facility parking lot. Resident stated " I ' ve got to go see family member. " Assisted back to facility x (times) 2. " Nurse #4 stated in an interview on 11/28/12 at 4:55 PM that on the morning of 10/14/12 she was going out of the front door of the facility and saw the resident in the parking lot. The Nurse stated it just so happened that she was going out the front door and saw the resident. The Nurse stated that the resident was found on the left side of the facility away from the carport and did not know how long the resident had been outside. The Nurse stated that she brought the resident back inside the building. The Nurse stated that the resident had gotten outside before. The Nurse stated that she did not know what was in place to prevent the resident ' s elopement but a chair alarm was put on his wheelchair when he first tried to get out. The MDS Coordinator stated in an interview on 11/29/12 at 4:35 PM that the only thing added to the resident ' s care plan was to call his family member. She stated that she did not know what else to add. The Coordinator stated that there had been a lot of in-services and elopement drills.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 14 An interview was conducted with the DON and the Administrator on 11/29/12 at 5:30 PM. The DON stated that after the resident got out of the building on 10/14/12 they did the same thing as before. Someone was assigned to sit with the resident the entire shift. The Administrator stated that they had elopement drills during which a staff person would pose as a resident that had eloped from the facility and the staff would search for the staff person posing as a resident. On 11/30/12 the estimated distance from the front door of the facility to the area of the parking lot where Nurse #4 found the resident on 10/14/12 was forty one feet. 1c. A nurse ' s note written by Nurse #5 dated 11/07/12 at 5:15 PM read: " Resident found outside by staff wandering around the building near dining room door. Resident had no falls noted from incidence. Asked what resident was doing, he stated, going out trying to get a car. " Nurse #5 stated in an interview on 11/28/12 at 5:10 PM that she was passing medications at 5:00 PM on 11/07/12. The Nurse stated that students were in the building that night and saw Resident #94 go out the front door but thought he was a visitor. The Nurse stated that she saw the resident ' s wheelchair inside the front door and there was no alarm sounding. The Nurse stated that she found Resident #94 standing outside at the corner of the facility on the sidewalk and he refused to come back in through the front door. The Nurse stated that one of the students and a housekeeping staff member assisted the resident around the back of the building and brought him	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 15 back in through the dining room door. The Nurse stated that the resident had tried to leave the facility earlier in the day. During the interview, the nurse was observed to walk out the front door to the area where she found the resident. The estimated distance from the front door to the left side corner of the facility was 125 feet. An interview was conducted with the Administrator and the DON on 11/28/12 at 5:30 PM. The Administrator stated that alarms were placed on all exit doors except for the front door and the dining room door. The Administrator stated that they purchased a system to alert staff to resident ' s trying to leave the building but the alarm was not very loud and could not be heard by staff so the system was sent back to the company. The Administrator stated they had looked at another system but the cost was between $10,000 to $15,000 dollars. 2a. Resident #76 was admitted to the facility on 07/15/10 with diagnoses that included Alzheimer ' s Disease, Anxiety Disorder, Hypertension and Diabetes Mellitus. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 09/26/12 showed that the resident was severely cognitively impaired. The MDS showed that the resident required extensive 2 person assist for mobility but once in the wheelchair was independent with mobility. The MDS did not note wandering behaviors for the review period. A nurse ' s note dated 08/09/12 at 10:20 AM by Nurse 6 read: " Resident up in wheelchair propelling self through facility. Nursing assistant	F 323	Realizing Resident #76 has exhibited exit seeking behaviors, all alarmed doors have been checked to ensure they are properly functioning, and personnel have been stationed at the front door 24 hours per day and 7 days per week to ensure the identified resident's attempts to exit the facility without assistance are appropriately re-directed.	11/29/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 16 looking out front window, saw resident in wheelchair at road. Resident brought in per staff, resident states, " I looked for cars. " Explained to resident please do not go outside, said he wouldn ' t. Will monitor. " The resident ' s care plan updated on 08/09/12 showed that the resident attempted to elope from the facility on 08/09/12. The goal on the care plan was for the resident to not suffer any injuries due to elopement attempts. The interventions included: Place resident in area where frequent observation is possible. Place chair alarm in chair. Alert staff to resident ' s elopement attempts. If resident is attempting to elope away from unit, instruct staff to stay with resident, converse and gently persuade resident to come back to designated area with them. Assign staff to account for resident ' s whereabouts throughout the day. Note which exits resident favors for elopement from facility. Alert staff working near those exits. Nurse #6 stated in an interview on 11/29/12 at 3:30 PM that Nursing Assistant (NA) #4 came to her and told her that she looked out the window and noticed Resident #76 outside. The Nurse stated that she went outside and observed the resident sitting in his wheelchair on the left side of the parking lot in front of the facility. The Nurse stated that she brought the resident back into the building and explained that he could not leave like that. The Nurse stated that she had been in-serviced on watching the resident and re-directing him to activities. The Nurse stated that she tried to involve the resident in activities to get his mind off trying to leave the facility. The Nurse stated that the resident had a bed and	F 323	For those residents having the potential to be affected by the same alleged deficient practice, the current staff received education training on November 29, 2012 regarding the facility's "Elopement Policy" and "Missing Persons Policy" including identifying the residents at risk for "exit seeking" behavior and on the procedures to implement if a resident eloped from the facility. All residents were reassessed using the facility's "Elopement Risk Assessment Form" on 11/29/12. No other residents were identified as being at risk for elopement at present. All exit doors are alarmed, with the exception of the front lobby door that is currently being supervised by a staff member 24 hours a day, 7 days a week until the facility's wander guard type system is installed by the facility's contractor. On 12/14/12 an "Accutech Resident Guard" wander system was ordered for the facility. The system will enable the front door to lock when approached by a resident wearing a "bracelet" that is designed to send a signal to the door. The system should be in place by end of January 2013. All staff will be educated on the mechanics of the system and made aware of the residents that are wearing the bracelets.	01/28/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 17 chair alarm pad that would alarm if he got up. NA #4 stated in an interview on 11/30/12 at 10:45 AM that on 08/09/12 she was in a resident ' s room making up beds and she opened the blinds in the room and saw Resident #76 sitting in his wheelchair sitting at the road where the cars were parked at the edge of the grass. The NA stated that she called the nurse on the hall and ran outside to get the resident. The NA stated that the resident ' s wheelchair was on the pavement and he was trying to scoot to get up on the grass. The NA stated that the resident was looking for a ride to an area where he used to live. The NA stated that she brought the resident back to his room and tried to get his mind off of going outside. The NA stated that this was not the first time that Resident #76 had got out of the building. The NA stated that visitors assumed it was OK for the resident to go outside but he could not unless someone was outside to supervise him. The NA stated that she had received inservices regarding the resident ' s elopement attempts. During the interview, the NA pointed out where the resident was found in the parking lot and stated that the resident was sitting between parked cars at the edge of the grass. There was an area of grass approximately 6-7 feet that led from the parking lot to a sidewalk that was along the edge of the street. The estimated distance from the front door of the facility to the street in front of the facility was 93 feet. An interview was conducted with the Director of Nursing (DON) and the Administrator on 11/29/12 at 5:30 PM. The DON stated that after the incident an elopement drill was completed on 08/13/12. The Administrator stated that during an	F 323	Nursing will monitor the residents with the system by placing the order on the resident's medication administration record. The nurse's will be instructed to observe the resident each shift to ensure the bracelet is on the resident. The nurse will then place his/her initials in the space provided on the individuals medication administration record attesting to the fact that the resident is wearing the bracelet. Furthermore, maintenance will be educated and instructed to check the battery life of the bracelet weekly using the battery test tool provided by the company to ensure it is working properly. The weekly battery test shall be logged by the Maintenance Director on the Battery Test form. The manufacturer will be notified immediately of any malfunctions with the system and while the system is down, a staff member will be placed again at the front door to stop any elopement attempts. Elopement drills are being done per facility policy and the "Elopement Protocol" is now incorporated into the new hire procedure.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 18 elopement drill a staff person would pose as a resident that had eloped from the facility and other staff would search for the staff person posing as the resident. The MDS Coordinator stated in an interview on 11/30/12 at 10:55 AM that the resident ' s last care plan meeting was held on 09/26/12 and that she had not included the resident ' s elopement on 08/09/12. 2b. A nurse ' s note dated 08/15/12 read: " Resident up in wheelchair propelling self, went out front door and down sidewalk part way. Staff redirected resident to come back in facility. Resident back in facility, no further attempts to leave. " Nurse #7 stated in an interview on 11/29/12 at 4:05 PM that Resident #76 had gotten out of the building and was partway down the walkway along the side of the building. The Nurse stated that she did not know how long the resident had been outside. During the interview, Nurse #7 was observed to go outside of the building to point out where she found the resident on 08/15/12. The Nurse stated that the resident had propelled his wheelchair from the front door to the right and to the third handicapped parking sign in the parking lot. The estimated distance was thirty six feet. The DON stated in an interview on 11/29/12 at 5:30 PM that elopement drills had been conducted with the staff on 08/01/12 and 08/03/12. The MDS Coordinator stated in an interview on 11/30/12 at 11:00 AM that the resident last care	F 323	The Maintenance Director will check the doors weekly to ensure the alarms are properly functioning; this will be documented on the "Door Alarm Check" form. The Administrator will monitor the audit forms for compliance weekly. The Director of Nursing and/or the Clinical Coordinator shall monitor the Weekly Wander Guard Bracelet Check log to ensure compliance. The MDS Coordinator will ensure that each resident placed on the "wander system" will be care planned accordingly. The Director of Nursing will monitor monthly for compliance. The Plan of Correction for this alleged deficient practice(s) has been incorporated into the facility's most recent Quality Assurance Committee meeting minutes and shall be evaluated for effectiveness no less than monthly for three months and quarterly thereafter on a continuing basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 19	F 323		

plan meeting was held on 09/26/12 and that no additional information regarding the resident ' s elopement was added to the resident ' s care plan.

2c. A nurse ' s note written by Nurse #5 dated 11/07/12 at 6:25 PM read: " Resident found outside in parking lot after being notified by visitor, in wheelchair. Resident brought back inside and oriented to facility. "

Nurse #5 stated in an interview on 11/29/12 at 5:44 PM that on 11/07/12 a visitor notified her that Resident #76 was in the parking lot. The Nurse stated that the resident had gotten off the edge of the carport. The Nurse stated that she re-oriented the resident to the facility and reminded him that it was cold outside and that he could get injured. The Nurse stated that she took the resident back to his room and he was watching television. The Nurse stated that she usually had the resident follow her while she passed medications. The Nurse pointed out the area where the resident was found and the estimated distance from the front door was twenty two feet.

The DON stated in an interview on 11/30/12 at 3:00 PM that Resident #76 was easily re-directed and that he wanted fresh air. The DON stated that elopement inservices were done on 11/08/12.

The Administrator was notified of the Immediate Jeopardy on 11/29/12 at 9:00 AM.

The facility provided an acceptable credible allegation of compliance on 11/30/12 at 1:00 PM.

The allegation of compliance indicated:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 20 CREDIBLE ALLEGATION OF COMPLIANCE On July 1, 2012 at approximately 6:45am, resident #94 was noted to be out of facility unattended. Staff at facility searched the facility and facility grounds per facility protocol. After it was determined resident was not on facility premises, the Police Department and the Director of Nursing were called to notify them of a missing resident at the facility. Approximately five minutes later, the Police Officer notified Nurse #1 that resident had been located approximately three blocks from facility. Director of Nursing had arrived and brought resident back to facility. Resident was assessed for any injuries, none noted. Resident stated to Director of Nursing that he wanted to leave to go see (name of family member). A nursing assistant was placed with resident for one on one care for the entire weekend. Resident was placed on the acute charting to monitor for any increased confusion and elopement risks. On October 14, 2012; resident was found out in facility parking lot in wheelchair by Nurse #4. Nurse brought resident back in facility. Resident stated he wanted to see (name of family member). Resident ' s family member notified of attempt and resident ' s request to see her. A sitter was placed with resident for the rest of the day. Staff made aware of residents elopement and Nurse #4 told all staff that they must be aware of the resident will elope. The next day, October 15, 2012, residents family member came and picked him up for LOA (leave of abscence) to his home. Returned to facility on October 16, 2012 and appeared to be very satisfied and happy. On November 7, 2012 at approximately 5:40am, resident was witnessed going out dining room door by Dietary Aide #1.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 21 Dietary Aide #1 and Nursing Assistant #3 got to resident just as he past the threshold of the door. His wheelchair tipped over and he fell to the ground. Resident got up and was back in his wheelchair when the staff members approached the resident. Nurse #2 was notified and resident was assessed for injuries from the fall. Resident was noted to have skin tears. Treatment was applied by nurse. Resident could move all extremites without difficulty. Resident ' s Responsible Party and Physician were notified of event. Nurse #2 made staff aware of residents elopement and the need for constant surveillance of this resident. On the same day at approximately 5:15pm, staff found resident outside of dining room door in his wheelchair. Resident stated he was going out to move his car. Resident was taken to room and a nursing assistant was placed with him for one on one care. Resident was noted to rest well the rest of the night. Responsible Party and Physician made aware. No more elopement attempts noted. This resident has been placed as of November 30, 2012 in an Assisted Living ' s Alzheimer ' s Unit. The move also brings him closer to his family. On August 9, 2012 , at approximately 10:20 am, resident #76 was witnessed by nursing assistant in his wheelchair sitting at the curbside. Resident immediately brought back in facility. Nurse #6 spoke with resident and asked him not to go outside without assistance as resident is easily redirected. Resident was taken to the dining room for bingo. After bingo, resident ' s family member came in facility and continued to stay with resident. A sitter has been placed with resident for twenty four hour to prevent any elopement attempts. Elopement of two residents at Elizabethtown	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 22 Healthcare and Rehabilitation Center: November 28, 2012: For those residents affected by the same deficient practice, due to the fact that the front door is not alarmed, personnel shall be stationed there 24-hours per day to ensure the identified residents do not elope or attempt to elope . All other exit doors to the facility are alarmed and are in proper working order. On November 29, 2012, all staff were re-in-serviced on the elopement protocol of the facility and were made aware of the two residents that being focused upon. The facility in-service instructed staff to approach residents calmly and redirect them as to not cause undue agitation are focused. The facility " Elopement Intervention Plan " is the system in place outlining how staff should respond to elopement of residents. This plan was also included in the in-service for staff on November 29, 2012. An updated photo was obtained of each resident and will be displayed at nurses station and will be updated as needed. All exit doors were secured immediately ensuring that alarms were in working order, the alarm sounds from the alarm mechanism attached to each door and can be heard throughout the entire facility. All staff were instructed that they are to respond to alarms heard throughout the facility. On November 28, 2012, at approximately 5:45pm rounds were immediately made by Maintenance Director, Administrator, Director of Nursing, MDS Coordinator, Social Worker, HR Director and Nurses to ensure all residents were accounted for. All residents were accounted for at that time. All exit door locking mechanisms were checked by the Maintenance Director immediately and were found in proper working order. The dining exit door was noted to be without proper alarming mechanism. The Maintenance Director installed	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 23 an alarm noted to have the tradename " EXIT STOPPER " alarm on the dining room exit door. The alarm is identical to the alarms on the other facility exit doors and alarms at the mechanism creating a loud noise that can be heard throughout facility. A sign was posted on the dining room exit door rerouting traffic. The surveyors were provided with documentation that the door for the dining room has been ordered and the date it will be installed. Elopement drills are being done quarterly, there are several documented twice monthly. All documentation of elopement drill and inservices have been provided to the surveyors. All residents have been reassessed using the " Elopement Risk Assessment " tool and will be careplanned accordingly. Any resident noted to be at risk for elopement will be assigned a 24 hour sitter. Identification of Residents that may be affected by the same alleged deficient practice and Monitoring: For those residents having the potential to be affected by the same alleged deficient practice, all residents ' were re-assessed by Administrative Nurses on November 29, 2012 using the facility ' s Elopement Risk Assessment form. No other residents were found to be at risk for elopement. The front door of the facility will be secured by placing an individual in lobby to stop any elopement attempts until an alarm system is installed for the front door. The door will be secured by an individual 24 hours a day/ 7 days a week until the " Wanderguard " system is installed. The surveyors were provided with the documentation from the company stating that the facility has ordered the system. Those residents identified as having a " having a history of leaving the facility without needed supervision, " shall	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 24 receive a 24 hour sitter. The front door shall remain supervised by staff 24-hours per day. Those residents identified as being at risk for elopement shall have an elopement care plan initiated and shall have approaches in place to prevent the residents elopement. Pursuant to the facility ' s Elopement Policy, all residents shall continue to be assessed for their elopement risk on admission and quarterly thereafter. All facility staff have been re in-serviced on the elopement policy and protocol and the missing persons protocol and policy. These policies have been in place since October 2006. The Elopement and Missing Persons " protocol will be included in the new hire procedure and will be given on a quarterly basis to all employees. In the case of missing persons, the hall nurse will assign individuals to search specific areas including, but not limited to: all rooms (identifying who is each bed and looking under the bed, bathrooms, closets, bathing rooms, offices, kitchen, freezers and coolers, storage rooms, linen rooms, laundry room, beauty shop, dining room, day room, conference room, maintenance storage, housekeeping and outside quadrants identified for the facility. All locked doors will be unlocked and checked. After checking locked rooms, the room should be locked. After initial search the missing person protocol will be followed accordingly. Individuals have been secured to man the front door 24 hours / day, seven days a week . The individual will be monitored by the administrative staff during the week and the Registered Nurses on the weekends. The Maintenance Director will check the doors weekly to make sure that they are functioning properly using the " Door Check " audit tool, which consists of the Maintenance	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 25 Director checking the door functions and placing his initials by the date checked. Quality Assurance of Elopement Risks: The Director of Nursing and/or Administrative Nurse Designee will review all new admissions and the " acute charting " of residents daily. During these reviews, the Director of Nursing and/or Administrative Nurse Designee will review records for safety concerns and will ensure preventative measures are implemented as needed. Residents identified as at risk for elopement will be followed in the " Patient At Risk " QA meetings weekly ensuring that all safety measures are in place. Director of Nursing and Administrative Nurses will continue to monitor the acute charting daily and bring any new " at risk " behaviors to the Careplan team and QA committee. In addition, Nurses have been instructed to complete an incident report on elopement attempts and investigation of the occurrence immediately after the attempt noted. All " at risk " behaviors will be followed in the QA meetings until deemed resolved by the committee. The credible allegation was verified by reviewing documentation provided by the facility of inservices and elopement drills completed as a result of the elopement incidences. Staff was questioned about their knowledge of elopement procedures, such as what to do if a resident left the facility and what to do if they heard the sounds of alarms. Staff were aware of the two residents that had eloped from the facility. In-services and elopement drills were verified by in-service sheets as well as staff interviews. Several staff was interviewed regarding the in-services they received on elopements, what to do if a resident was missing and what to do when	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 26 a sitter (one-on-one staff) took a break. Staff interviewed and their responses are noted below: 11/30/12 at 2:00 PM NA# 12 stated she had received an in-service on elopements. She revealed the two residents that would attempt to leave the facility were Resident #76 and Resident #94. NA# 12 stated if she was a sitter for one of the residents and needed to take a break, she would inform someone and she would not leave the resident until someone took her place. She stated if a resident was missing she would inform the Administrator and assist in the search of the facility. 11/30/12 at 2:15 PM NA# 13 stated she had been in-serviced on elopements. She stated if she heard an alarm sound, she would locate where the sound of the alarm was coming from. She revealed if a resident was missing from the facility she would notify her supervisor and management staff and she would assist in the search of the facility. NA#13 stated Resident #94 and Resident #76 were residents that would attempt to leave the facility. She revealed if she was assigned one-on-one with a resident and needed a break, she would inform someone and she would not leave the resident until someone relieved her. 11/30/12 at 2:20 PM Staff Nurse #8 on 400 Hall. She stated that she had just received an in-service on elopements. She stated if a resident had a staff member watching them one-on-one, when the staff member took a break, another staff member must cover during the break. If a resident was missing, staff members would look for the resident, notify the administrator and if unable to find the resident call the police. 11/30/12 at 2:30PM Nursing Assistant #9 (NA#9) stated that she had just received an in-service on elopements. If she was unable to find a resident,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 27	F 323		

she would notify the charge nurse and look for the resident. If doing one-on-one with a resident she would get someone to relieve her for breaks. If a chair alarm went off, she would go and check on the resident. If she saw a resident going out the door she would bring the resident back in.
11/30/12 at 2:35 PM Housekeeping Staff# 1 stated that if she saw a resident going out the door, she would bring them back in and notify the nurse.
11/30/12 at 2:45 PM a picture was observed of Resident #76 at the nurse' s station as being a resident at risk for elopement. Nurse #6 stated that the other resident (Resident #94) had been transferred to another facility. The Nurse stated that she had just received an in-service on elopements. The Nurse stated that if a resident was observed going out the door, she would bring them back in and notify the DON or the Administrator. The Nurse stated that staff sitting with resident that were being observed after elopement attempt must be relieved by another staff member for breaks.
11/30/12 at 2:50 PM Staff Nurse#4 sated she had received an in-service on elopements. The Nurse stated that Resident #76 and Resident #94 would try to go out of the building. If she observed these residents going out the door, she would bring the residents back in and notify administration. She further stated that Staff assigned to one-on-one with residents after elopement attempt must be relieved by another staff member for breaks.
11/30/12 at 3:00 PM NA #10 stated she had just received an in-service on elopements. The NA stated Resident #94 and Resident #76 were at risk for elopement and if she saw one of them going out the door, she would bring them back in and notify the nurse. The NA stated that if doing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 28 one-on-one with a resident, she must be relieved by another staff member for breaks. 11/30/12 at 3:15 PM NA# 7 stated Resident #76 was at risk for elopement. If she saw him going out the door would bring him back in and notify the nurse. The NA stated that she had just received an in-service on elopements and if sitting with a resident after an attempt to get out of the building she would not leave to take a break until someone relieved her. 11/30/12 at 3:20 PM NA# 8 stated she has just had an in-service on elopements. She stated Resident #76 would try to go out of the front door. If she saw him try to go out, she would bring him back in and notify the nurse. 11/30/12 at 3:25 PM NA# 9 stated she had received an in-service on elopements. She stated Resident #94 and Resident #76 had gotten out of the building. If she saw one of them going out of the door she would bring them back in and notify the nurse. The NA stated if she was one-on-one with a resident that had tried to elope, she would need to sit with the resident for the NA to take a break. 11/30/12 at 3:28 PM NA# 10 stated that she had received an in-service on elopements. She stated Resident #76 was at risk for elopement. If she saw him trying to leave the building she would notify the nurse. If sitting with the resident after an elopement attempt, she would not leave to take a break until someone relieved her. 11/30/12 at 3:45 PM NA #11 stated she received in-services on elopement. She stated if a resident eloped from the facility, she would notify her supervisor and the management staff and she would assist in the search, both inside and outside of the facility. She stated if she heard an alarm sound she would locate where the alarm	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 323	Continued From page 29 was coming from. She stated the two residents that would attempt to leave the facility were Resident #76 and Resident #94. She revealed that if she was a sitter and it was time for her break, she would let someone know about it and would not leave her assigned resident until someone took her place. Care Plans and Elopement Risk Assessments were verified for completion for all residents. The resident at risk for elopement that was still in the facility was observed for supervision by sitters throughout the day. Sitters were questioned about what to do when they took breaks. Doors were checked for verification of alarms on them.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility staff failed to wash their hands with soap and water between handling soiled and clean dishes to prevent cross contamination of clean dishes. The findings include:	F 371	F371 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 371	Continued From page 30 During the kitchen sanitation inspection on 11/28/12 at 9:42 AM, dietary staff #1 was observed stacking soiled dishware and dietary staff #2 was observed scrapping, rinsing and loading soiled dishes onto a dish rack. At 9:44 AM dietary staff #2 was observed moving from the soiled dishes to use her soapy left hand to pull the clean dish rack out and push the soiled dish rack into the dish machine without washing her hands with soap and water in between moving from the soiled to clean dishes. At 9:50 AM dietary staff # 2 was observed scrapping, rinsing and loading soiled dishes onto a dish rack. She then moved from the soiled dishes to pull the clean dish rack out onto the dish machine shelf without washing her hands with soap and water in between. At 9:52 AM dietary staff # 1 was observed to wash her hands with soap and water, moved to pull the clean dish racks dietary staff # 2 had touched further out onto the dish machine shelf to dry. At 9:59 AM dietary staff # 2 was observed rinsing and loading soiled dishes, she then moved to pull clean dish rack out onto the dish machine shelf without washing her hands in between. During an interview the dietary staff on 11/28/12 at 10:00 AM, she stated, " That is the way I was trained. As long as I only touch the dish rack I thought I was okay. " In an interview with the Certified Dietary Manager on 11/28/12 at 10:05 AM, she stated, " They will all be In-Serviced today. I thought if they only touched the dish rack it was okay. All these dishes will be rewashed now. "	F 371	F 371 While no residents were specifically identified as having been affected by this alleged deficient practice; the plates and plate rack were rewashed immediately. For those residents having the potential to be affected by the same alleged deficient practice, the dietary manager in-serviced all dietary staff on 11/28/12 on the prevention of cross contamination and the importance of handwashing when moving from the soiled to clean areas while washing the dishes. On 12/06/12, the Registered Dietician provided additional staff training to all dietary employees on the policy entitled "Dishwashing Policy and Procedure". The policy provides staff with measures to prevent cross contamination when washing the dishes. The Dietary Manager will monitor for compliance by using the form entitled "Dishwashing Checklist" weekly times four monthly thereafter to ensure accuracy. In addition, the Registered Dietician shall monitor the "Dishwashing Checklist" no less than monthly during routine consultation visits. The Dietary Manager shall report any inconsistencies in accuracy to the Quality Assurance Committee meeting monthly.	11/28/12 01/13/13

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
	345210	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 Federal Register, using the Existing Health Care section of the LSC and its referenced publications. This building is type V(111) construction , one story with a complete automatic sprinkler system.	K 000	K 012 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).	
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation on 12/19/12 at approximately 9:00 AM onward the following was noted: 1) The ceiling radiation damper in the resident bathrooms were not not maintained clean and in good condition.	K 012	No residents were identified as having been affected by this alleged deficient practice. 1. All ceiling radiation dampers in facility have been thoroughly cleaned to remove any buildup. To ensure that this alleged deficient practice does not recur, the Maintenance Director and/or his designee will monitor the radiation dampers on a monthly basis using the Housekeeping / Maintenance Room Check sheet. The Maintenance Director will report any inconsistencies to the Quality Assurance Committee quarterly.	2/1/13
K 025 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/9/13

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
	345210	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 025	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation on 12/19/12 at approximately 9:00 AM onward the following was noted: 1) The smoke wall in the attic located on 300 hall has an access door that could not be closed and sealed smoke tight due to cables running through the opening. All holes and opening in the smoke wall will need to sealed in order to maintain the required required fire resistance rating of the smoke barrier. 42 CFR 483.70(a)	K 025	K 025 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not in any manner, constitute an admission to the validity of the alleged deficient practice(s) No residents were affected by this alleged deficient practice. The 300 hall smoke wall access door has been repaired to seal smoke tight. All holes in the smoke wall have been sealed to maintain the required fire resistant rating of the smoke barrier.	2/1/13
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on 12/19/12 at approximately 9:00 AM onward the following was noted:	K 029	To ensure that this alleged deficient practice does not recur, the Maintenance Director and/or his designee will monitor the access doors on a quarterly basis to ensure the doors are close smoke tight. The Maintenance Director will report any inconsistencies to the Quality Assurance Committee quarterly.	

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
	345210	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 2 1) The dry storage room in the litchen was blocked open with a #10 food can preventing the door from closing.	K 029	K 029 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued particlpation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. No residents were identified as having been affected by the alleged deficient practice. The dry storage room door was unblocked immediately. The dietary staff have been in-serviced on the importance of never blocking a door in the facility. To ensure this alleged deficient practice does not recur, the Maintenance Director and/or his designee will monitor the doors of the facility weekly using the audit tool entitled, "Maintenance / Housekeeping Room Rounds".	12/19/12
K 052 SS=D	42 CFR 483.70(a) 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 12/19/12 at approximately 9:00 AM onward the following was noted: 1) There are deficeincied cited in the Fire Alarm Inspection report dated 10/19/12 that at the time of the inspection were not not corrected.	K 052		
K 056 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in	K 056	K 052 While no residents were identified as having been affected by this alleged deficient practice, the deficiencies cited in the Fire Alarm Inspection report dated 10/19/12 will be corrected.	2/1/13

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
	345210	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 056	Continued From page 3 accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on 12/19/12 at approximately 9:00 AM onward the following was noted: 1) The shower curtain in shower room #2 was a solid curtain installed at ceiling height and did not have the mesh top. 2) The sprinkler heads in the laundry room were covered in lint and not maintained in good condition. 3) The sprinkler heads in the attic on 300 hall were blocked with insulation that has fallen down between the rafters preventing the sprinkler from providing proper coverage. 4) There are defeciencies cited in the Sprinkler Inspection Report date 9/19/12 that at the time of the survey were not corrected.	K 056	K 056 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). No residents were identified as having been affected by this alleged deficient practice. 1. The shower curtain in shower room #2 was replaced with a curtain with mesh. 2. The sprinkler heads in the laundry were cleaned thoroughly removing all buildup on 12/19/12. 3. The insulation in the attic has been properly secured to all sprinklers to provide proper coverage. 4.The deficiencies cited in the Sprinkler Inspection on 9/19/12 were corrected on 1/8/13. The Maintenance Director and/or his designee will monitor the sprinkler heads, weekly using the Maintenance/ Housekeeping Rounds form to ensure compliance.	2/1/13
K 067 SS=F	42 CFR 482.41(a) 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,	K 067		

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
	345210	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 067	Continued From page 4 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation on 12/19/12 at approximately 9:00 AM onward the following was noted: 1) An access door was not provided for in the HVAC unit for the front build section in order to allow for inspection and maintenance. 42 CFR 483.70(a)	K 067	K 067 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). An access door will be installed in the front section of the building.	2/1/13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation on 12/19/12 at approximately 9:00 AM onward the following was noted: 1) An electrical disconnect in required for the residential stove in the activity room to prevent residents from turning on the stove when not in use. 42 CFR 482.41(a)	K 147	K 147 No residents were identified as having been affected by this alleged deficient practice. An electrical disconnect was installed for the residential stove in the activity room and the activity staff was educated on the mechanics of the switch. The Maintenance Director will monitor the electrical disconnect during his weekly rounds to ensure that it is working properly. The Maintenance Director will report any inconsistencies to the Quality Assurance Committee meeting quarterly.	1/5/13

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
	345210	A. BUILDING 02 - BUILDING 02 B. WING _____	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 Federal Register, using the Existing Health Care section of the LSC and its referenced publications. This building is type V(111) construction , one story with a complete automatic sprinkler system.	K 000	K 029 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).	
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 12/19/12 at approximately 9:00 AM onward the following was noted: 1) The corridor door to the soiled utility room on 400 hall did not close, latch and seal at the time of the survey.	K 029	No residents were identified as having been affected by this alleged deficient practice. The corridor door to the soiled utility room on 400 hall was repaired to close, latch, and seal. To ensure that this alleged deficient practice does not recur, the Maintenance Director and/or his designee will monitor the doors on a weekly basis using the Door Checklist. The Maintenance Director will report any discrepancies to the Quality Assurance Meeting quarterly.	12/20/12
K 067 SS=F	42 CFR 483.70(a) 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	K 067		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/9/13

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
	345210	A. BUILDING 02 - BUILDING 02 B. WING _____	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 067	Continued From page 1 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 12/19/12 at approximately 9:00 AM onward the following was noted: 1) The exhaust ducts from the radiation dampers located in the attic in the to the rigid metal piping in the attic were not maintained in good condition and proper design. The flexible duct's outer liner was deteriorated and separating from the tubing. The air ducts shall be Class 0 or Class 1 rigid or flexible air ducts tested in accordance with UL 181, Standard for Safety Factory-Made Air Ducts and Air Connectors, and installed in conformance with the conditions of listing. 42 CFR 482.41(a)	K 067	K 067 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). No residents were identified as having been affected by this alleged deficient practice. New metal Class 1 duct was installed on 1/4/13. K 104 No residents were identified as having been affected by this alleged deficient practice. The smoke damper located in the smoke wall in the attic on 400 hall was repaired to operate properly.	1/4/13 2/1/13
K 104 SS=E	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 12/19/12 at approximately 9:00 AM onward the following was noted: 1) The smoke damper located in the smoke wall in the attic on 400 hall did not operated when tested.	K 104		

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
	345210	A. BUILDING 02 - BUILDING 02 B. WING _____	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(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 104	Continued From page 2 42 CFR 483.70(a)	K 104		