STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345380	A. BUILDING ______ B. WING ______	C 10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REHAB AND HC CTR AT VILLAGE GR	1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

(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 No deficiencies were cited as a result of the complaint investigation conducted on 10/24/13. Event ID #2DVA11.	F 000	**Standard Disclaimer:** This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not in any manner constitute an admission to the validity of the alleged deficient practice.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356 F356 F356	**How corrective action will be accomplished for those residents found to have been affected by the deficient practice:** No residents were affected by the deficient practice. The direct care nursing hours during the time period were above the state requirement of 2.1 PPD on 10/22/13, 10/23/13, and 10/24/13. **How corrective action will be accomplished for those residents having potential to be affected by the deficient practice:** Nurse staffing hours will be posted daily at the reception area in the front main entrance of the facility. This will include the facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses, Licensed practical nurses, or licensed vocational nurses (as defined under state law), and Certified	10/24/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] NHA
TITLE: Administrator
(X6) DATE: 11/23/13

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.

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F 356	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to post the daily facility staffing (nursing) in an area that could easily be seen or located by the residents, staff and visitors for three days of the recertification survey. The facility also failed to post the facility staffing (nursing) for three days of the recertification survey on 10/22/13, 10/23/13 and 10/24/13. During an observation on 10/21/13 at 6:30 pm during the initial tour the facility staffing was unable to be located. During an observation on 10/22/13 at 9:30 am the facility staffing was unable to be located. During an observation on 10/23/13 at 9:45 am the facility staffing was unable to be located. During an observation on 10/24/13 at 10:20 am accompanied by the director of nursing (DON) when questioned regarding the facility staffing escorted the state agency to the back of the facility known as the "employee entrance" per the DON. The facility staffing was observed posted on the hall wall of the employee entrance dated 10/21/13. The location where the facility staffing was posted was not easily identifiable without having to ask. Thereafter, the DON escorted the state agency to a information closed glass board on the 200 B hall that revealed no staffing posted as indicated by the DON "we post it here also." In an interview on 10/24/13 at 10:30 am, the unit coordinator acknowledged that she was the designated person that was responsible for	F 356 **F356**	**Standard Disclaimer:** This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not in any manner constitute an admission to the validity of the alleged deficient practice. nurse aides; current resident census will also be included. The nurse staffing hours will be above the state requirement of 2.1 PPD; if hours are less than the state requirement, the facility will ensure to find enough direct patient care staff to work on the floor. The DON/designee will be responsible for posting daily nursing hours Monday through Friday. On Saturday and Sunday the Weekend Supervisor/designee will be responsible for posting daily nursing hours. Nursing hours posted will be signed off by two nurses (Registered nurse/Licensed practical nurse/ or Licensed vocational nurse). The DON/designee will in-service staff whom may be involved with the daily nursing hours calculation. The daily nursing hours posted form will be copied to the Administrator and DON daily to ensure accuracy.	**12/14/13**

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F 356	Continued From page 2 posting the facility staffing. When questioned regarding the posting of the staffing for 10/22/13, 10/23/13 and 10/24/113 she indicated that she would have to "look around in her office to see if the staffing sheets were located there."	F 356	**Standard Disclaimer:** This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not in any manner constitute an admission to the validity of the alleged deficient practice.	
	In an interview on 10/24/13 at 10:35 am, the director of nursing stated that she expected the facility staffing to be posted daily. She concluded going forward she would ensure the facility staffing was posted daily, and in an area that could be easily found/observed.	F356	**What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:** Nurse staffing hours will be posted daily at the reception area in the front main entrance of the facility. This will include the facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses, Licensed practical nurses, or licensed vocational nurses (as defined under state law), and Certified nurse aides; current resident census will also be included. The nurse staffing hours will be above the state requirement of 2.1 PPD; if hours are less than the state requirement, the facility will ensure to find enough direct patient care staff to work on the floor.	
	In an interview on 10/24/13 at 10:45 am, the unit coordinator reported that she posted the facility staffing for 10/24/13, after being notified by the state agency.			

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F356 The DON/designee will be responsible for posting daily nursing hours Monday through Friday. On Saturday and Sunday the Weekend Supervisor/designee will be responsible for posting daily nursing hours. Nursing hours posted will be signed off by two nurses (Registered nurse/Licensed practical nurse/ or Licensed vocational nurse). The DON/designee will in-service staff whom may be involved with the daily nursing hours calculation. The daily nursing hours posted form will be copied to the Administrator and DON daily to ensure accuracy. **12/14/13**

F356 **How the facility plans to monitor its performance to make sure that solutions are sustained:**

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F356 The daily nursing hours posted form will be copied to the Administrator and DON daily. The Administrator/DON/designee will audit the nurse staffing hours posted once a week for four weeks and quarterly thereafter. The results of the audit will be brought to the next scheduled quality assurance meeting. Any discrepancies will be addressed immediately and staff whom are involved will be in-serviced on the deficient practice or disciplined as deemed necessary by the Administrator/DON/designee. **12/14/13**

COMPLETION DATE: 12/14/13

DEC 0 2 2013
CONSTRUCTION SECTION

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

PRINTED: 11/15/2013
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
	345380	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REHAB AND HC CTR AT VILLAGE GR	1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	**Standard Disclaimer:** This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not in any manner constitute an admission to the validity of the alleged deficient practice.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by:	K 018	**How corrective action will be accomplished to correct the deficient practice:** Door closures were installed to the dish washing room on 11/25/13. Doors are to remain closed unless necessary for staff to exit/enter. **How we will identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective actions will be taken:** All doors in the facility that may be out of compliance with 42 CFR 483.70 (a) will have a door closure installed. **What measure will be put into place or what systemic changes we will make to ensure that the deficient practice does not recur:** Staff will be in-serviced on the importance of keeping doors closed that have closures: not to prop doors for any reason. Door closures will be	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11/29/13

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

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K 018	Continued From page 1 Surveyor: 27871 Based on observations and staff interview at 8:30 am onward, the following items were noncompliance, specific findings include: doors to dish washing room did not have latching hardware on them for keeping doors closed. 42 CFR 483.70(a)	K 018	**Standard Disclaimer:** This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not in any manner constitute an admission to the validity of the alleged deficient practice.	
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: Surveyor: 27871 Based on observations and staff interview at 8:30 am onward, the following items were noncompliance, specific findings include: 1. door to Medical records room is not self closing. 2. door to supply room is also not self closing(by Admin. office). 42 CFR 483.70(a)	K018	added to the Monthly maintenance checklist to ensure compliance. **How the corrective actions will be monitored to ensure the deficient practice will not recur:** Doors that have closures will be added to the monthly checklist for maintenance items that need to be checked for LSC compliance. Any deficiencies shall be immediately fixed and Maintenance Director and Administrator made aware so appropriate disciplinary actions/education can occur. This topic will be brought to the next QA meeting and monitored monthly thereafter.	12/29/13
		K029	**How corrective action will be accomplished to correct the deficient practice:** Door closures were installed to the medical records room and the door to the supply room on 11/25/13. Doors are to remain closed unless necessary for staff to exit/enter to conduct their work.	
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

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K 052	Continued From page 2 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	K 052	**Standard Disclaimer:** This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not in any manner constitute an admission to the validity of the alleged deficient practice.	
	This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at 8:30 am onward, the following items were noncompliance, specific findings include: during test on fire alarm system, batteries went dead on system(with loss of power). Also several horns on horn/strobe devices did not work (2A). 42 CFR 483.70(a)	K029	**How we will identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective actions will be taken:** All doors in the facility that may be out of compliance with 42 CFR 483.70 (a) will have a door closure installed. **What measure will be put into place or what systemic changes we will make to ensure that the deficient practice does not recur:** Staff will be in-serviced on the importance of keeping doors closed that have closures: not to prop doors for any reason. Door closures will be added to the Monthly maintenance checklist to ensure compliance.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at 8:30	K 062	**How the corrective actions will be monitored to ensure the deficient practice will not recur:** Doors that have closures will be added to the monthly checklist for maintenance items that need to be checked for LSC compliance.	

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K 062	Continued From page 3 am onward, the following items were noncompliance, specific findings include: 1. facility could not provide proper documentation that 3 year full flow test had been performed on sprinkler system. 2. facility could not provide proper documentation that 5 year obstruction investigation test had been performed on sprinkler system. 42 CFR 483.70(a)	K 062	**Standard Disclaimer:** This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not in any manner constitute an admission to the validity of the alleged deficient practice.	
		K029	Any deficiencies shall be immediately fixed and Maintenance Director and Administrator made aware so appropriate disciplinary actions/education can occur. This topic will be brought to the next QA meeting and monitored monthly thereafter.	12/29/13
		K052	**How corrective action will be accomplished to correct the deficient practice:** The batteries for the fire alarm system were replaced on 11/14/13. The horn/strobe devices for the fire alarm system were ordered on 11/14/13 and are scheduled to be installed on 12/11/13. **How we will identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective actions will be taken:** The battery back-up system for the fire alarm system will be upgraded to ensure if fire alarm system runs out of power that there is proper backup.	

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K052 The horn/strobe devices will be placed on the monthly maintenance checklist to be checked at a minimum of once during a facility fire drill during that month. Any deficiencies shall be immediately fixed and Maintenance Director and Administrator made aware so appropriate disciplinary actions/education can occur.

What measure will be put into place or what systemic changes we will make to ensure that the deficient practice does not recur: Maintenance staff will be in-serviced on the battery and horn/strobe devices for the fire alarm system and educated on how we can prevent this from occurring again. The deficiencies will be added to the Monthly maintenance checklist to ensure compliance. Any deficiencies shall be immediately fixed and Maintenance Director and Administrator made aware so appropriate disciplinary actions/education can occur.

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K052 **How the corrective actions will be monitored to ensure the deficient practice will not recur:** The deficiencies will be added to the Monthly maintenance checklist to ensure compliance. Any deficiencies shall be immediately fixed and Maintenance Director and Administrator made aware so appropriate disciplinary actions/education can occur. This subject shall be brought to the next QA meeting and checked monthly thereafter. 12/29/13

K062 **How corrective action will be accomplished to correct the deficient practice:** The 3 year full flow test of the sprinkler system is scheduled for 12/10/13-12/11/13. The 5 year obstruction investigation test for the sprinkler system will be performed on 12/10/13-12/11/13.

How we will identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective actions will be taken:

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K062 Both the Maintenance Director and the fire alarm system company shall place the next tests due for the 3 year full flow test and the 5 year obstruction investigation test on their company calendars. Maintenance staff will be made aware of the deficient practices. The maintenance monthly checklist will include when the last inspections occurred and when the next due date is.

What measure will be put into place or what systemic changes we will make to ensure that the deficient practice does not recur: Maintenance staff will be in-serviced on the 3 year full flow test that is needed and the necessity to have a 5 year obstruction test on the sprinkler system. The deficiencies will be added to the Monthly maintenance checklist to ensure compliance and shall state when the last inspection occurred and the next due date. Any deficiencies shall be immediately fixed and Maintenance

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K062 Director and Administrator made aware so appropriate disciplinary actions/education can occur.

How the corrective actions will be monitored to ensure the deficient practice will not recur: The deficiencies will be added to the Monthly maintenance checklist to ensure compliance and shall state when the last inspection occurred and the next due date. Any deficiencies shall be immediately fixed and Maintenance Director and Administrator made aware so appropriate disciplinary actions/education can occur. This topic will be brought to the next QA meeting and monitored monthly thereafter. 12/29/13

Completion date: 12/29/13