STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and family interviews, the facility failed to maintain dignity for 4 of 8 sampled residents as evidenced by not eliminating pests in resident ' s environment. (Resident #2, #5, #7 and #8). The findings included: 1. Resident #2 admitted to the facility on 8/12/15. The quarterly Minimum Data Set (MDS) dated 11/23/16, indicated that Resident #2 was cognitively intact. During an observation on 1/13/17 at 10:00 AM, Resident #2 was lying in bed and just received his breakfast. There were live roaches crawling around the base board underneath the resident ' s bed. In addition, there were dead roaches under the bed, around the floor of the side table and in 6 compartment storage bins. During an interview on 1/13/17 at 10:00 AM, Resident #2 stated the roaches would crawl on him at night while he was sleeping. The resident stated he had reported this concern to maintenance, his guardian and administration. In addition, the resident reported this problem had been going on for several months and even though the room was sprayed, the roaches came out even more and stated " It really upsets me	F 241	All residents are treated with dignity and respect, Ecolab treated Residents #2, #5, #7 and #8 for pest 1/13/2017. The above residents' room received a deep cleaning on 1/31/2017 to include areas beneath the bed, and behind the furniture. All residents could be affected by this practice therefore all rooms have been treated for pest by Ecolab (the contracted exterminator company). The direct caregivers will be re-educated by the SDC regarding storage of resident's personal belongings, and reporting evidence of pest to the administrator immediately. This in-service will be included in the new employee orientation program for direct care givers. Ecolab will treat the facility for pest control 2x weekly for 2 weeks, weekly x4, then twice monthly to ensure compliance with eliminating pest. The Administrator, DON, SDC, and Charge Nurses will monitor (through direct observation and resident interview) 10 resident/rooms 2x weekly x4 weeks,	2/11/17

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

Electronically Signed | 02/08/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 241	Continued From page 1 that I have to sleep with roaches. " 2. Resident #7 was admitted to the facility on 12/10/15. The Minimum Data Set (MDS) dated 7/16/16 indicated Resident #7 was cognitively intact. During an interview on 1/13/17 at 10:24 AM, Resident #7 was watching television and stated that roaches crawled up the walls on a weekly basis. Resident #7 reported that some were seen a few nights ago. Resident #7 further stated that even though the room had been sprayed several times, the roaches came from other rooms especially from the bathroom since the bathrooms were shared. In addition, Resident #7 stated " Something different needed to be sprayed because they come out a lot at night. No one should have to sleep with roaches or any other bugs crawling all around them. The staff just kill them and keep it moving. " During an interview on 1/13/17 at 11:00 AM, the guardian reported during her visit she had observed dead roaches under Resident #2 ' s bed, behind the night table and in the bathroom. In addition, the guardian reported she had spoken with maintenance and management about the roaches, but nothing seem to be done. Resident #2 had reported to the guardian and facility staff that roaches were crawling on him at night and he didn ' t want to go to sleep because of them. The guardian stated when it was reported to management in November, they told her the bug people had already been out and additional time was needed for the solution that was used to work. The guardian and resident were upset it was taking the facility so long to address the problem.	F 241	weekly x4, then monthly thereafter until compliance is achieved in eliminating pest in the residents environment. Data results will be analyzed and reviewed at the facility monthly QAPI meeting for 3 months with subsequent plan of correction as needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 241	Continued From page 2	F 241		

3. Resident #8 was admitted to the facility 11/10/15. The quarterly Minimum Data Set (MDS) dated 1/7/17, indicated Resident #8 was cognitively intact.

During an interview on 1/13/17 at 10:24 AM, Resident #8 stated he had seen some roaches in his room and the bathroom in the past few days. Resident #8 reported even when maintenance sprayed or the bug people sprayed it made them bugs come out more as though they were being fed. Resident #8 reported the roaches could be seen more at night and when the lights were turned on. The resident further added most of the time you end up stepping on them because the spray that was being used wasn ' t working. Resident #8 reported the roach problem had been reported to maintenance and other staff and stated the housekeeping department came in and swept them up and kept going.

4. Resident #5 was admitted to the facility on 2/5/14. The quarterly Minimum Data Set (MDS) dated 11/15/16 indicated Resident #5 had some cognition impairment.

During a telephone interview on 1/13/17 1:30 PM, Resident #5 ' s family member stated she had seen both dead and live roaches in Resident #5 ' s room on the wall next to bed, the nightstand and on the floor next to the bed. The family member reported the facility sprayed rooms individually with their own bug spray to control the roaches.

During an interview on 1/13/17 at 2:54 PM, the Director of Nursing (DON) indicated she was aware there was a problem with roaches. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 241	Continued From page 3 expectation was for the Maintenance Director to contact the pest control company to resolve the problem. The DON also reported residents and family members had reported concerns with the roaches and they were informed that the pest control company had been contacted. During an interview on 1/13/17 at 3:41 PM, the Administrator indicated the expectation when concerns of any roaches or bugs are noted, the pest control company should be contacted immediately. The Maintenance Director should spray the identified areas with local product until the pest control company arrives. The Administrator acknowledged resident and family concerns with the roaches but was unaware of any reported concerns of roaches crawling on residents.	F 241		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) 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 label personal care equipment for residents in five of six sampled rooms (Rooms 7, 21, 23, 27 and 45). Findings included: A tour of resident halls in the facility yielded the following observations: A. On 01/13/17 at 9:00 a.m., one unlabeled urinal was observed in the bathroom of Room 21. Two resident rooms with four residents shared the bathroom.	F 253	Bath basin, urinals and bedpans that were found in rooms #7,#21,#23,#27 and #45 were immediately discarded. New urinals, bath basins and bedpans were replaced and labeled. All residents have the potential to be affected: Resident room audit was conducted by the DON/Charge Nurse to identify other rooms where urinals, bath basins, or bed	2/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 4 B. On 01/13/17 at 4:41 p.m., one bedpan with an emesis basin lying in it was observed on the bathroom floor of Room 27. Both items were unlabeled. An unlabeled washbasin and an unlabeled urine collection device for the toilet were also present. Two resident rooms with four residents shared the bathroom. C. On 01/13/17 at 4:45 p.m., two unlabeled urine collection devices nested together were observed on the bathroom floor of Room 23. An unlabeled urinal and unlabeled bedpan were also on the floor. Two resident rooms with four residents shared the bathroom. D. On 01/13/17 at 5:00 p.m., two stacked washbasins with a urinal and emesis basin placed inside one of the basins were observed on the bathroom floor of Room 45. None of the four items were labeled. Two resident rooms with four residents shared the bathroom. E. On 01/13/17 at 5:15 p.m., five unlabeled washbasins were observed stacked on top of the toilet tank in the bathroom of Room 7. One basin contained a dirty spoon and five plastic bottle caps. Two resident rooms and five residents shared the bathroom. In an interview on 01/13/17 at 5:00 p.m., Nurse #8 stated that the resident items in Room 23 should be labeled and not stored on the bathroom floor. The nurse tossed all the items in a trash bin. In an interview on 01/13/17 at 5:10 p.m., Nurse Aide #2 stated that the facility policy is to label all items and not store them on the floor. In an interview on the morning of 01/14/17, the Director of Nursing indicated that all staff are trained on how to handle resident care	F 253	pans were improperly labeled or stored. Items identified through this process were immediately discarded and replaced. The DON or SDC will re-educate the CNA's regarding proper labeling and storage of resident's bath basins, urinals and bedpans. The in-service will be included in the new employee orientation program for direct care giver. The DON/SDC and Department Managers will conduct room rounds on 10 rooms daily x4 weeks then weekly x4weeks and monthly x3 to ensure appropriate storage of personal items. Data results will be analyzed and reviewed at the facility monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 5 equipment. She shared her expectation that personal care equipment is labeled and stored off the floor. When asked if a facility policy was available for review, an explicit policy on the cleaning and storing of personal care equipment was not provided.	F 253		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to generate a written physician order for physician review and signature after nurse receipt of a telephone order for one of one sampled resident (Resident #3). Findings included: Two facility policies were reviewed. The undated policy on " Physician Countersignatures of Verbal/Telephone Orders " stated that " The record of each telephone order shall include the name of the physician giving the order ...date and time of the order, content of the order, and name of person receiving the order. " The undated policy on " Medication and Treatment Orders " stated that " verbal orders must be recorded immediately in the resident ' s chart by the person receiving the order ...Verbal orders must be signed by the prescriber at his or her next visit. " Resident #3 was admitted 08/24/16. Diagnoses included hemiplegia following CVA	F 281	Resident #3 no longer resides in the facility. All residents have the potential to be affected by this practice. A one time audit will be performed by DON, SDC and Unit Supervisor on current residents' treatment administration record (TAR)to ensure that corresponding physician orders are present. Any discrepancies identified through this process will receive MD notification with a physician order clarification written The DON or SDC will re-educate the licensed nurses on the policy and procedure on obtaining physician Verbal/Telephone orders with an emphasis on documenting on the physician telephone order sheet	2/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 281	Continued From page 6 (cerebrovascular accident) affecting non-dominant left side and generalized muscle weakness. A Brief Interview of Mental Status score of 0, indicating severe cognitive impairment, was recorded on the admission Minimum Data Set (MDS). The quarterly MDS dated 12/20/16 indicated the presence of a Stage 1 or higher pressure ulcer. The Treatment Administration Record (TAR) for November 2016 and December 2016 contained the following order: " Cleanse left buttock with normal saline, apply Xeroform and dry dressing Q MWF [every Monday, Wednesday and Friday] and PRN [as needed for] soiled/dislodged dressing. " The Start Date was listed as 11/14/16 and Stop Date was 12/29/16. No corresponding written and signed physician order was present in the medical record at the time of the survey. The order was not present in a printout of the signed Physician Orders " Current Orders as of 29-Nov-2016 5:14 PM. " In an interview 01/14/17 at 10:45 a.m., Nurse #1 reviewed the online TAR and said the order was designated as a telephone order. She provided the name of Nurse #8 who entered the order. In a phone interview 01/14/17 at 3:30 p.m., Nurse #12 indicated that she remembered receiving this order over the phone from the physician on 11/24/16. The Director of Nursing was present in the room and the call was placed on speaker phone. She stated that she did not write the order on a physician order form but entered it directly into the computer. In an interview on 01/14/17, Nurse #13, a manager in Staff Development, described the policy for taking off orders. The nurse entered the order from the written physician order form into the electronic program QMAR. Another nurse on the same shift verified that it was entered	F 281	This inservice will be included in the new employee orientation program for licensed nurses. The DON, SDC, Medical Records or Charge Nurse will audit 5 residents treatment administration records with physician's order 2x weekly for 4 weeks then monthly x3 months to ensure accuracy in entering of verbal/telephone orders. Data results will be analyzed and reviewed at the facility's monthly QAPI meeting x3 months with a subsequent plan of correction as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 281	Continued From page 7 correctly. When a telephone order was received, the correct procedure was for the nurse who received the order to write it on a physician order form, enter it in the computer and a second nurse would verify from the written order that it had been entered correctly. In an interview on 01/14/17 at 4:00 p.m., the Director of Nursing confirmed that the physician telephone order she and Nurse #12 received on 11/24/16 was not written down at the time. There was no written order for the physician to sign and no written order for the second nurse to verify.	F 281		
F 469 SS=E	483.90(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (h)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, residents, staff and family interviews and record review, the facility failed to maintain a pest free environment for 4 of 8 sampled residents (Resident #2 #5 #7 and #8) in 1 of 2 dining rooms and 2 of 2 shower rooms. Findings included: Resident #2 admitted to the facility on 8/12/15. The quarterly Minimum Data Set (MDS) dated 11/23/16, indicated that Resident #2 was cognitively intact. During an observation on 1/13/17 at 10:00 AM, Resident #2 was lying in bed and just received his breakfast. There were live roaches crawling around the base board underneath the resident ' s bed. In addition, there were dead roaches under the bed, around the floor of the side table and in 6 compartment storage bins.	F 469	The facility must maintain an effective pest control program. Resident #2,#5,#7 and #8, dining room and shower rooms were sprayed for pest on 1/13/2017. All residents could be affected by this practice therefore all rooms have been treated for pest by Ecolab (the contracted exterminator company). The direct caregivers will be re-educated by the SDC regarding storage of resident's personal belongings, and reporting evidence of pest to the administrator immediately. This in-service will be included in the new employee orientation program for direct care givers.	2/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 469	Continued From page 8 During an interview on 1/13/17 at 10:00 AM, Resident #2 stated the roaches would crawl on him at night while he was sleeping. The resident stated he had reported this concern to maintenance, his guardian and administration. In addition, the resident reported this problem had been going on for several months and even though the room was sprayed, the roaches came out even more and stated " It really upsets me that I have to sleep with roaches. " Resident #7 was admitted to the facility on 12/10/15. The Minimum Data Set (MDS) dated 7/16/16 indicated Resident #7 was cognitively intact. During an observation on 1/13/17 at 10: 24 AM, there were small roaches crawling along side of the walls and on the counter top in the bedroom. There were also dead roaches observed on the floor around the back of the toilet in the bathroom. During an interview on 1/13/17 at 10:24 AM, Resident #7 was watching television and stated that roaches crawled up the walls on a weekly basis. Resident #7 reported that some were seen a few nights ago. Resident #7 further stated that even though the room had been sprayed several times, the roaches came from other rooms especially from the bathroom since the bathrooms were shared. In addition, Resident #7 stated " Something different needed to be sprayed because they come out a lot at night. No one should have to sleep with roaches or any other bugs crawling all around them. The staff just kill them and keep it moving. " Resident #8 was admitted to the facility 11/10/15.	F 469	Ecolab will treat the facility for pest control 2x weekly for 2 weeks, weekly x4, then twice monthly to ensure compliance with eliminating pest. The Administrator, DON, SDC, and Charge Nurses will monitor (through direct observation and resident interview) 10 resident/rooms 2x weekly x4 weeks, weekly x4, then monthly thereafter until compliance is achieved in eliminating pest in the residents environment. Data results will be analyzed and reviewed at the facility monthly QAPI meeting for 3 months with subsequent plan of correction as needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 469	Continued From page 9	F 469		

The quarterly Minimum Data Set (MDS) dated 1/7/17, indicated Resident #8 was cognitively intact.

During an interview on 1/13/17 at 10:24 AM, Resident #8 stated he had seen some roaches in his room and the bathroom in the past few days. Resident #8 reported even when maintenance sprayed or the bug people sprayed it made them bugs come out more as though they were being fed. Resident #8 reported the roaches could be seen more at night and when the lights were turned on. The resident further added most of the time you end up stepping on them because the spray that was being used wasn ' t working. Resident #8 reported the roach problem had been reported to maintenance and other staff and stated the housekeeping department came in and swept them up and kept going.

During an observation on 1/13/17 at 10:30 AM, roaches were observed crawling on the walls and around the base board in the main dining room. The roaches could been seen near the kitchen door area which was connected to the dining but not coming from the kitchen. There was a large amount of food left on the floor in the corners of the dining room. Several tables, countertop and chairs had were noted to have leftover food from the breakfast meal.

During an interview on 1/13/16 at 10:30 AM, the housekeeper (HK#1) reported roaches were observed in resident rooms, dining areas and shower rooms. HK#1 stated when any bugs, roaches, ants etc. were observed it was reported to the maintenance director. HK#1 identified observations of roaches in Resident #2, #7 and #8 ' s rooms within the past few days. HK#1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 469	Continued From page 10	F 469		

added that there had been an increase of live and dead roaches throughout the facility even though the bug people have come to spray. Additionally, housekeeping reported they had been cleaning up more dead bugs in the past few months. Some residents had complained to management but the roaches were still present.

During an interview on 1/13/17 at 11:00 AM, the guardian reported during her visit she had observed dead roaches under Resident #2 ' s bed, behind the night table and in the bathroom. In addition, the guardian reported she had spoken with maintenance and management about the roaches, but nothing seem to be done. Resident #2 had reported to the guardian and facility staff that roaches were crawling on him at night and he didn ' t want to go to sleep because of them. The guardian stated when it was reported to management in November, they told her the bug people had already been out and additional time was needed for the solution that was used to work. The guardian and resident were upset it was taking the facility so long to address the problem.

During an observation on 1/13/17 at 11:30 AM, Resident #2 was being showered in one of 3 shower stalls. Two of the empty shower stalls were noted to have roaches crawling up and down the walls and base board in shower room #1. The Maintenance Director was called to the shower room to confirm the presence of roaches in the shower area after the completion of the resident shower.

During an interview on 1/13/17 at 11:35 AM, NA#4 and NA#5, both NA ' s reported roaches had been observed in resident rooms, shower

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 469	Continued From page 11	F 469		

areas and throughout the facility. NA#5 reported the bug people had come to the facility the previous week and since they had come the roaches started to come out even more. Both NAs reported when the roaches or any other bugs were seen it was reported to the Maintenance Director who would contact the bug people. Both NAs indicated that management was aware of the roach problem as other residents and/or family had reported the problem as well.

During an observation on 1/13/17 at 11:45 AM, the Maintenance Director was asked to come to shower room #1. The Maintenance Director confirmed there were roaches crawling along the walls of the empty shower stalls.

During an interview on 1/3/17 at 11:45 AM, the Maintenance Director indicated he was aware of roaches present within the facility. He reported residents, staff and family had reported observations of roaches in resident rooms and other areas of the facility. He added that the pest control person had been in the facility to spray two weeks ago and in between visits he would spray the identified areas with a product from the local store. The Maintenance Director reported that a call had been placed to the pest control person a few days ago and it was told to him they would be out to spray again next Tuesday and could not come any sooner due to work backlog and weather. He also reported that several rooms were identified where roaches had been observed and he did the spray with the product from the local store until the pest control person could return. The Maintenance Director reported there was a contract change in November. In addition, he was uncertain why the products

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 469	Continued From page 12	F 469		

being used by the pest control company was not effective.

During an observation on 1/13/17 at 12:07 PM, shower room #2 was observed and there were several dead and active roaches crawling from behind a black book case and along the walls and base board of the shower room and stall area.

During an interview on 1/13/17 at 12:10PM, HK #2, indicated maintenance was responsible for getting the bug people to spray the building when roaches or bugs were reported by residents, staff or family. HK#2 reported residents and family had reported roaches and he himself had observed them throughout the facility. HK#2 further stated after the rooms were sprayed, the housekeeping staff would go in and do a deep cleaning. HK#2 stated residents and family had reported being upset about the roaches and questioned what would be done. HK#2 identified rooms and dining rooms where roaches were observed the most. HK reported their responsibilities were to sweep, mop, and dust and clean under beds, empty trash, clean air conditioners, bathrooms etc.

Resident #5 was admitted to the facility on 2/5/14. The quarterly Minimum Data Set (MDS) dated 11/15/16 indicated Resident #5 had some cognition impairment.

During a telephone interview on 1/13/17 1:30 PM, Resident #5 ' s family member stated she had seen both dead and live roaches in Resident #5 ' s room on the wall next to bed, the nightstand and on the floor next to the bed. The family member reported the facility sprayed rooms individually with their own bug spray to control the roaches.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 469	Continued From page 13	F 469		

During an interview on 1/13/17 at 2:14 PM, HK#3 reported she had seen roaches and ants in resident rooms within the past few days to weeks. HK#3 indicated it was reported to the Maintenance Director and the Maintenance Director came to the room and sprayed some stuff down and then the room was deep cleaned. HK#3 reported roaches had been seen since November. The bug people had been in the building, but the roaches had been coming out even more since they had sprayed. HK#3 indicated responsibilities were to sweep, mop, dust, clean under beds, furniture, bathrooms, and clean beds and deep clean several rooms per week per the cleaning checklist.

During an interview on 1/13/17 at 2:54 PM, the Director of Nursing (DON) indicated she was aware there was a problem with roaches. The expectation was for the Maintenance Director to contact the pest control company to resolve the problem. The DON also reported residents and family members had reported concerns with the roaches and they were informed that the pest control company had been contacted.

During an interview on 1/13/17 at 3:00 PM, NA#6 indicated roaches were observed and reported to maintenance and management. The bug people have come several times but the roaches remain.

During an interview on 1/13/17 at 3:41 PM, the Administrator indicated the expectation when concerns of any roaches or bugs are noted, the pest control company should be contacted immediately. The Maintenance Director should spray the identified areas with local product until the pest control company arrives. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 469	Continued From page 14 Administrator acknowledged resident and family concerns with the roaches but was unaware of any reported concerns of roaches crawling on residents. A review of the grievance log dated 9/28/16 revealed the family member for Resident #5 reported roaches were seen on the night stand and on the radio. A maintenance work order dated 12/20/16 was also submitted for observation of roaches in resident room. A review of the pest control company report dated 11/18/16 and 12/28/16, revealed the facility had been sprayed for roaches in resident rooms, shower rooms and dining rooms. There were no recommendations documented on the service form.	F 469		
F 490 SS=E	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and family interviews, the administration, the facility failed to maintain dignity for 4 of 8 sampled residents as evidenced by not eliminating pests in resident ' s environment. (Resident #2, #5, #7 and #8). The failed to manage and follow-up on the effectiveness of the pest control program for 4 of 8 sampled residents (Resident #2 #5 #7 and #8) in 1 of 2 dining rooms and 2 of 2 shower rooms.	F 490	The facility must use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well being. Resident #2, #5,#7 and #8 rooms have been treated to eliminate All residents could be affected by this practice therefore all rooms have been	2/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 490	Continued From page 15 The findings included: 1. This tag was crossed referenced to F241. Based on observations, resident, staff and family interviews, the facility failed to maintain dignity for 4 of 8 sampled residents as evidenced by not eliminating pests in resident ' s environment. (Resident #2, #5, #7 and #8). 2. This tag was crossed referenced to F469. Based on observations, residents, staff and family interviews and record review, the facility failed to maintain a pest free environment for 4 of 8 sampled residents (Resident #2 #5 #7 and #8) in 1 of 2 dining rooms and 2 of 2 shower rooms.	F 490	treated for pest by Ecolab (the contracted exterminator company). Resident belongings will be checked and taken out of boxes upon admission to facility. The direct caregivers will be re-educated by the SDC regarding storage of resident's personal belongings, and reporting evidence of pest to the administrator immediately. This in-service will be included in the new employee orientation program for direct care givers. Ecolab will treat the facility for pest control 2x weekly for 2 weeks, weekly x4, then twice monthly to ensure compliance with eliminating pest. The Administrator, DON, SDC, and Charge Nurses will monitor (through direct observation and resident interview) 10 resident/rooms 2x weekly x4 weeks, weekly x4, then monthly thereafter until compliance is achieved in eliminating pest in the residents environment. Data results will be analyzed and reviewed at the facility monthly QAPI meeting for 3 months with subsequent plan of correction as needed	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		2/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 514	Continued From page 16 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to maintain accurate treatment documentation fo two (2) of three (3) sampled residents with pressure ulcers (Resident #1 and Resident #3).	F 514	Resident #1 and #3 no longer resides in the facility All residents have the potential to be affected by this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 514	Continued From page 17 Findings included: 1. Resident #1 was readmitted on 11/14/16 with the diagnoses of left hemiplegia, chronic atrial fibrillation on warfarin (an anticoagulant), chronic ischemic heart disease, and anemia, end stage renal disease on hemodialysis, hypertension and diabetes mellitus. Review of the undated policy titled, Charting and Documentation revealed, " All observations, medication administered, services performed, etc., must be documented in the resident clinical records. " Review of the most recent physician order dated 11/15/16, revealed " Clean shear to R (right) buttock with NS (normal saline) and apply Xeroform (a petroleum dressing) daily " . Scheduled 07:00-14:59 (7:00 AM-2:59PM). This order was discontinued on 12/4/16, per the treatment administration record (TAR). Review of the most recent physician order dated 11/16/16 revealed " Cleanse sacral wound with normal saline, apply Santyl ointment (a wound debrider) & cover with dry dressing daily. " Scheduled daily at 9:00 (AM). Stop date was 12/04/16. Review of the most recent physician order dated 11/28/16, revealed, " Skin prep bilateral heels and left and right lateral feet QD (every day). Review of the November 2016 treatment administration record (TAR) and nursing notes revealed no documentation of the right buttock wound dressing change on the nineteenth (19).	F 514	Therefore a one time audit was perform on residents' with pressure ulcers treatment record for physician order accuracy and treatment administration documentation. The physician will be notified and treatment orders will be clarified for any discrepancies identified through this process. The DON and or SDC will re-educate the licensed nurses to the policy and procedure for documenting completion of treatments as ordered. This inservice will be included in the new employee orientation program for licensed nurses. The DON, SDC, Medical Records or Charge nurse will audit 5 residents treatment records 2x weekly for 4 weeks then weekly x4 weeks then monthly x3 months to ensure accuracy in treatment documentation. Data results will be analyzed and reviewed at the facility's monthly QAPI meeting x3 months with a subsequent plan of correction as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 514	Continued From page 18	F 514		

Review of the wound care physician noted dated 11/28/16, revealed the wound was resolved.

Review of the November 2016 treatment administration record (TAR) and nursing notes revealed no documentation of the sacral wound dressing change on the sixteenth (16), nineteenth (19), twentieth (20), twenty-sixth(26), twenty-seventh (27), twenty-ninth(29) and thirtieth (30). Review of the December TAR and nursing notes no documentation on the first,(1), second (2), fifth (5), sixth (6), seventh (7), eight (8), ninth (9), tenth (10), twelfth (12), fourteenth (14), fifteenth (15), sixteenth, seventeenth (17), eighteenth (18), nineteenth (19), twenty-first (21), and twenty-second (22).

Review of the November 2016 treatment administration record (TAR) and nursing notes revealed no documentation of skin prep to bilateral heels and lateral feet on the twenty-eighth (28), twenty-ninth (29), and thirtieth (30). Review of the TAR and nursing notes for the month of December revealed no treatment to the bilateral heels and feet documented on the first, (1), second (2), third (3), fourth (4), nineteenth (9) and eighteenth (18).

On 1/13/17 at 4:15 PM Nurse # 6 indicated the wound care nurse changed the dressings. When there was no wound care nurse. The nurse on the cart changed the dressings and documented on the TAR.
On 1/13/17 at 5:21 PM Nurse # 3 indicated wound treatments were done by the wound care nurse. When the wound care nurse was assigned to a medication cart or was off, then the nurse who had the patient did the treatment and documented on the TAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 514	Continued From page 19	F 514		

On 01/14/17 at 9:50 AM Nurse # 2 acknowledged wound and treatment documentation was absent on the TAR. She indicated she provided the wound care during the week unless, she was moved to a medication cart. Then the nurse who had Resident #1 administered the treatment and documented.
On 01/14/17 at 9:54 AM Nurse # 1 indicated the missing initials indicated the treatment was not done or the nurse forgot to document.
On 01/14/17 at 12:49 PM, Director of Nursing indicated she was not aware of the missing treatment documentation. She indicated it was a computer problem.

2. Resident #3 was admitted 08/24/16. Diagnoses included multiple sclerosis, Bell ' s palsy, blindness, hemiplegia following CVA and generalized muscle weakness.
A Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive impairment, was recorded on the admission Minimum Data Set (MDS). The quarterly MDS dated 12/20/16 indicated the presence of a Stage 1 or higher pressure ulcer.
A physician order dated 11/24/16 in the Treatment Administration Record (TAR) read " Cleanse left buttock with normal saline, apply Xeroform and dry dressing Q MWF [every Monday, Wednesday and Friday] and PRN [as needed for] soiled/dislodged dressing. " The Stop Date listed was 12/29/16.
No documentation or staff initials were present in the TAR for the month of November from the Start Date of the treatment through the end of the month (11/24/16 - 11/30/16). Only two of the 29 dates in December for which the order applied were initialed as completed: 12/12/16 and 12/28/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	**411 S LASALLE STREET DURHAM, NC 27705**

(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 514	Continued From page 20	F 514		

On 01/14/17 at 9:50 a.m., Nurse #2 acknowledged that wound and treatment documentation was absent on the TAR. She indicated that she provided wound care during the week unless she was assigned to a medication cart. In that case, the nurse who was assigned care of Residents #1 and #3 was responsible for administering and documenting the treatment.
In an interview on 01/14/17 at 9:54 a.m., Nurse #1 indicated that missing initials on the TAR indicated that the treatment was not done or the nurse forgot to document it. Another possibility she shared was that documentation of treatment was entered by the nurse in the computer at the time of treatment but that it was not showing up on the computer screen at the present time.
On 01/14/17 at 12:49 p.m. the Director of Nursing indicated that she was not aware of missing treatment documentation for Residents #1 and #3. She confirmed that there was a problem with the blue laptop computer used to record treatments.
3. The physician order for Resident #3 dated 11/24/16 in the TAR read " Cleanse left buttock with normal saline, apply Xeroform and dry dressing Q MWF [every Monday, Wednesday and Friday] and PRN [as needed for] soiled/dislodged dressing. " The Stop Date listed was 12/29/16.
The physician order was inconsistent with two Wound Care Specialist Evaluations, a Wound Assessment Report and a nursing Progress Note. Resident #3 was evaluated by the physician on 11/28/16. He noted on the Wound Care Specialist Evaluation form the presence of a Stage 2 pressure ulcer on the right buttock.
On an evaluation dated 12/08/16 the physician again indicated the pressure ulcer was located on the resident ' s right buttock.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	**411 S LASALLE STREET DURHAM, NC 27705**

(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 514	Continued From page 21	F 514		

The Wound Assessment Report completed by the Wound Treatment Nurse on 11/28/16 recorded the wound location as the right buttock. A nursing progress note dated 11/30/16 by the Wound Treatment Nurse documents a " right buttock Stage 2. "

In an interview 01/13/17 at 10:30 a.m. the Wound Treatment Nurse (Nurse #2) indicated she accompanied the wound doctor on his weekly rounds.

In an interview 01/14/17 at 10:00 a.m. Nurse #2 reviewed the documentation for the pressure ulcer location and confirmed that the wound was present on the right buttock.

In an interview 01/14/17 at 10:10 a.m., Nurse #1 reviewed the documentation for the pressure ulcer location and stated that the reference to left buttock in the physician order was most likely a transcription error as the order was entered into the computer.

In an interview 01/14/17 at 3:30 p.m., Nurse #12 stated the physician order was received as a telephone order. She acknowledged that she may have put the wrong location when she entered the order into the computer.