STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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
E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted on 10/10/22 through 10/15/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID NVHF11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 10/10/22 through 10/15/22. Event ID# NVHF11 The following intakes were investigated: NC00193336, NC00191411, NC00190749, NC00190210, NC00188988, NC00187620, NC00185035, and NC00184016. Intake NC00187620 resulted in immediate jeopardy. 16 of the 30 complaint allegation(s) were substantiated resulting in deficiencies. Immediate Jeopardy was identified at: F600 and F610 CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.12 at tag F610 at a scope and severity (J) The tags F600 and F610 constituted Substandard Quality of Care. Immediate Jeopardy began on 3/25/22 and was removed on 10/15/22. An extended survey was conducted.	F 000		

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

Electronically Signed | 11/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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	Continued From page 1 This statement of deficiencies was posted late due to State IT issues.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 550	Continued From page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to promote dignity by delaying answering a call bell device for 1 of 4 residents reviewed for dignity. (Resident #172) Findings included: Resident #172 was admitted to the facility on 9/30/2022, and diagnoses included gastroenteritis, an inflammation of stomach and intestines. The care plan dated 10/5/2022 included a focus for gastroenteritis, and interventions included observing for nausea and administering medications as ordered by the physician. The admission Minimum Data Set (MDS) assessment dated 10/6/2022 indicated Resident #172 was cognitively intact. On 10/10/2022 at 11:15 a.m. in an interview with Resident #172, she stated she was nauseated, and she had rung the call bell device all night and all morning, and no one had come to her room to tell them she needed some medication for nausea. She stated the wash basin lined with clean paper towels observed at the foot of the bed was in case she vomited. She stated she had not vomited but was unable to eat her breakfast due to the nausea. Resident #172 stated she was	F 550	Tower Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Tower Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tower Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F550 Resident Rights/Exercise of Rights On 10/10/22, resident #172 was administered anti-nausea medication. Resident #172 reported medication was effective.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 550	Continued From page 3 tired of waiting for someone to answer the call device so she could get some medication for nausea. On 10/10/2022 at 11:21 a.m., a continuous observation started when Resident #172 was observed activating the call bell device. On 10/10/2022 at 11:31 a.m., the call light above Resident #172's door was observed lit, and Nurse #1 and Nurse Aide #5 were observed providing care to other residents across the hallway. Nurse #1 was observed on 10/10/2022 at 11:33 a.m. exiting resident's room across the hallway to the medication cart positioned on the adjacent hallway. On 10/10/2022 at 11:37 a.m., the audible call bell device system was observed at the centralized nurse's station, and the screen of the call bell system indicated Resident #172's call bell device had been activated for eighteen minutes. There were no facility staff members observed at the centralized nurse's station. On 10/10/2022 at 11:43 a.m., Admission Coordinator was observed entering Resident #172's room. The Admission Coordinator was observed telling Resident #172, "I'll go get your nurse" and did not turn off the call bell device. On 10/10/2022 at 11:47 a.m. Nurse #4 was observed entering Resident #172 room and exiting with call bell device still activated. An audible overhead page was heard for Nurse #1 to the nurse's station. On 10/10/2022 at 11:54 a.m. NA #5 was observed entering Resident #172's room and turning off the call bell device. On 10/10/2022 at 11:44 a.m. in an interview with Admission Coordinator, she stated she went to Resident #172's room after seeing her call bell device had been on the longest at the nursing station. She stated she left the call bell device activated to go inform Nurse #1 Resident #172	F 550	On 10/17/22, the Social Worker and/or Activities Director initiated resident questionnaires with all alert and oriented residents regarding call bell response time. The Social Worker, hall nurse and/or Activities Director will address all concerns identified during the questionnaires to include addressing resident care needs when indicated and education of staff. Questionnaires will be completed by 11/23/22 On 11/7/22, the Director of Nursing and Assistant Director of Nursing initiated an in-service with all nurses, nursing assistants, social worker, accounts payable, accounts receivable, therapy staff, housekeeping staff, activity staff, maintenance staff, receptionist, supply clerk, medical records and admission staff regarding Call Lights with emphasis on all staff are responsible to address call lights timely and/or obtain appropriate staff for assistance if unable to meet resident needs. In-service will be completed by 11/23/22. After 11/23/22, any nurses, nursing assistants, social worker, accounts payable, accounts receivable, therapy staff, housekeeping staff, activity staff, maintenance staff, receptionist, supply clerk, medical records and admission staff who have not worked or received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses, nursing assistants, social worker, accounts payable, accounts receivable, therapy staff, housekeeping staff, activity staff, maintenance staff,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 550	Continued From page 4 requested nausea medication. On 10/10/2022 at 11: 48 a.m. in an interview with Nurse #4, she stated she went to Resident #172's room because she observed Resident #172's call bell device was activated at the nurse's station. She further stated her call bell device had been on the longest and was left activated because Resident #172's needs had not been met. On 10/10/2022 at 12:35 p.m. in an interview with Resident #172, she stated she received her medication for nausea around 12:10 p.m. and was feeling better and able to rest. On 10/11/2022 at 1:55 p.m. in an interview with Nurse Aide (NA) #5, she stated there was not always a staff member positioned at the nurse's station monitoring the call bell system to notify the staff on the halls when resident's call device was activated. She stated on 10/10/2022, there was only one nurse and one nurse aide assigned to the 100-hall, and she was not able to answer the activated call bells in a timely matter due to providing care to other residents. NA #5 stated Resident #172 complained of nausea when the breakfast meal tray was delivered to her room, and she informed Resident #172's nurse. On 10/11/2022 at 2:40 p.m. in an interview with Nurse #1, he stated Resident #172's call for assistance was missed because her room was located around a corner of the hallway, and staff were unable to visualize Resident #172's call bell light outside the room above the door. He stated he did not know Resident #172 needed assistance on 10/10/2022. He stated there was not always someone at the nurse's station to identify which resident had called out for	F 550	receptionist, supply clerk, medical records and admission staff will be in-serviced during orientation regarding Call Lights. 10 resident care observations will be completed by the Business Office Staff and Admission Staff weekly x 4 weeks then monthly x 1 month utilizing the Call Light Audit Tool. This audit is to ensure all staff stop to address call lights timely and/or obtain appropriate staff if unable to meet resident needs. The Business Office Staff, Admission Staff and assigned nurse will address all concerns identified during the audit to include addressing resident needs and/or re-training of staff. The Director of Nursing will review the Call Light Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Business Office Staff or Admissions Director will present the findings of the Call Light Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Call Light Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 550	Continued From page 5 assistance, and nursing staff on the hall were providing care to other residents. When asked if NA #5 informed him on 10/10/2022 Resident #172 was nauseated that morning, he stated, "not sure" and stated he was new to the hall and was trying to learn the residents. He stated he responded accordingly when told of resident's needs. On 10/11/2022 at 2:58 p.m. in an interview with Director of Nursing (DON) #1, she stated on 10/10/2022 there was no staff member assigned to the nurse's station to monitor the call bell device system. She stated call bell devices were left activated until the need of the resident was met, and any staff member that heard the call bell device alarm were to look down the hallway to determine whose outside call light was lit to go determine what the resident needs. DON #1 stated there was sufficient staff assigned to the 100-hall on 10/10/2022 to answer the call device in a timely matter to meet the needs of the Resident #172. On 10/13/2022 at 5:10 p.m. in an interview with Nurse #4, she stated Resident #172 should not had waited an extensive time for staff to answer the call bell device. She stated nursing staff should check the call bell device system at the nurse's station and call bell lights when audibly heard to determine where to go to determine what assistance the resident needs. On 10/14/2022 at 5:42 p.m. in an interview with the Administrator, she stated call bell devices were to be answered in a timely manner to meet needs of the residents.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences	F 558		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 558	Continued From page 6 CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview and staff interviews, the facility failed to place the call bell device within the reach for 1 of 1 resident reviewed for accommodation of needs. (Resident #171) Findings included: Resident #171 was admitted to the facility on 10/1/2022. The care plan dated 10/2/2022 indicated Resident #171 was at risk for falls, and interventions included keeping the call light within reach of Resident #171. The admission Minimum Data Set (MDS) assessment dated 10/6/2022 indicated Resident #171 was moderately impaired cognitively, required assistance with all activities of daily living and was incontinent of urine and stool. On 10/10/2022 at 11:11 a.m., Resident #171 was observed sitting in his recliner chair that was positioned four feet from the left side of the bed. The call bell device was observed wrapped around the bed rail located at the head of the bed on the left side of the bed out of reach for Resident #171.	F 558	F558 Reasonable Accommodations On 10/10/22, nursing assistant (NA) #5 placed call bell within reach of resident #171. On 10/30/22, the Administrator initiated an audit of all call bells to ensure that call bell was placed in reach of all residents to promote accommodation of resident needs and maintain health and safety of the residents. All areas of concern were immediately addressed by the Administrator to include placing call bell in reach of resident and education of staff. Audit will be completed by 11/23/22 On 11/7/22, the Director of Nursing and Assistant Director of Nursing initiated an in-service with all nurses, nursing assistants, social worker, accounts payable, accounts receivable, therapy staff, housekeeping staff, activity staff, maintenance staff, receptionist, supply clerk, medical records and admission staff regarding Call Lights with emphasis on ensuring call lights are in reach of the resident at all times. In-service will be completed by 11/23/22. After 11/23/22,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 558	Continued From page 7 On 10/10/2022 at 11:19 a.m. in an interview with Nurse Aide (NA) #5, she stated Resident #171 used his call device to communicate his needs to the nursing staff and immediately stated after recognizing Resident #171 did not have his call bell device in reach "He needs his call device." NA #5 was observed unwrapping the call bell device from the bed rail and placing the call bell on the right side of the recliner within Resident #171's reach. NA #5 stated physical therapy assisted Resident #171 into the recliner earlier that morning. On 10/10/2022 at 3:41 p.m. in an interview with Physical Therapy Aide (PTA) #1, she stated when she found Resident #171 sitting on the side of the bed that morning, she assisted him to the bathroom and into the recliner. She stated call bell devices were to be placed in the reach of residents, and she placed the call bell device in reach of Resident #171. When informed the call bell was observed wrapped around his bed rail out of his reach from the recliner, she stated, "Oh, OK." On 10/11/2022 at 2:49 p.m. in an interview with Nurse #1, he stated Resident #171 used the call bell device to communicate his needs to the nursing staff, and the recliner should had been positioned next to the bed for Resident #171 to reach his call bell device. On 10/11/2022 at 2:54 p.m. in an interview with Interim Director of Nursing (DON), she stated the call bell device should always be in the reach of Resident #171. On 10/14/2022 at 5:35 p.m. in an interview with	F 558	any nurse, nursing assistants, social worker, accounts payable, accounts receivable, therapy staff, housekeeping staff, activity staff, maintenance staff, receptionist, supply clerk, medical records and admission staff who have not worked or received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses, nursing assistants, social worker, accounts payable, accounts receivable, therapy staff, housekeeping staff, activity staff, maintenance staff, receptionist, supply clerk, medical records and admission staff will be in-serviced during orientation regarding Call Lights. 10 resident care observations will be completed by the Business Office Staff and Admission Staff weekly x 4 weeks then monthly x 1 month utilizing the Call Light Audit Tool. This audit is to ensure call lights are always placed within reach of the resident. The Business Office Staff, Admission Staff and hall nurse will address all concerns identified during the audit to include addressing resident needs, placing call light in reach of the resident and/or re-training of staff. The Director of Nursing will review the Call Light Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Business Office Staff or Admissions staff will present the findings of the Call Light Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 558	Continued From page 8 the Administrator, she stated call bell device was to be in the reach of Resident #171.	F 558	The Executive QAPI Committee will meet monthly for 2 months and review the Call Light Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and	F 577	F577 Right to Survey Results	11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 577	Continued From page 9 staff interviews, the facility failed to inform residents (Resident #1, #23, #43, #8, #21 and #45) the location of the state inspection results and failed to display state inspection results accessible to a wheelchair bound resident (Resident 8) for 6 of 6 residents in attendance of the resident council meeting. The findings included: On 10/12/2022 at 2:05 p.m. during a resident council meeting, Resident #1, Resident #23, Resident #43, Resident #8, Resident #21 and Resident #45 stated state inspection results were not made available for residents to read and did not know the location of the state inspection results. On 10/12/2022 at 2:55 p.m. the state inspection results black binder for the facility was observed on the wall in a clear file holder, with the base of the clear file holder located approximately forty-eight inches from the floor, in the hallway across from the receptionist desk. A white label reading "Survey Results" was observed on the bound of the black binder facing upward toward the ceiling. There was no label identifying the state inspection results binder observed on the clear file holder or the front of the black binder. On 10/12/2022 at 3:05 p.m. in an interview with the Administrator, she stated during a past Resident Council Meeting when the Ombudsman spoke to the resident council, the residents were informed and shown where the Survey Inspection Results binder was located. She stated the State Inspection Results were not identifiable located in the black binder in the clear file holder across from the receptionist desk and would label the	F 577	On 10/12/22, the Administrator and Maintenance Director relocated the State Inspections Results Book to a level readily accessible to residents and family members and at a level accessible to wheelchair bound residents to include resident #8. A bright colored sign was placed at the location to help identify location for residents with instructions to see Director of Nursing and/or Administrator for any questions or additional assistance if needed. On 11/7/22, a resident council meeting was held to review resident right to examine the results for the most recent survey of the facility conducted by Federal or State surveyors to include any plan of correction and to review where these results were located. The Activities Director will be reviewed how to obtain assistance if need to review survey results. The Activity Director will educate any alert or oriented resident who did not attend the resident council meeting. Education of residents will be completed by 11/23/22. On 11/7/22, the facility consultant in-serviced the Administrator, Director of Nursing, Social Worker and Activities Director regarding Survey History Posting with emphasis on posting survey history results at an area readily assessible to residents to include but not limited to residents who are wheelchair bound and education of residents on where survey history results are located. All newly hired	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 577	Continued From page 10 outside of the clear file holder. On 10/12/2022 at 3:10 p.m. Resident #8 was observed unable to reach the State Inspection Results binder while sitting in her wheelchair and stated she was unable to read the label on the bound of the binder facing toward the ceiling. Resident #8 informed the Administrator that the clear file holder needed to be below the light switch for her to reach the black binder.	F 577	Social Worker, Administrator, Director of Nursing and Activity Director will be in-serviced during orientation regarding Survey History Posting. The Social Worker and/or Activities Director will complete resident questionnaires with all alert and oriented residents weekly x 4 weeks then monthly x 1 month utilizing Resident Questionnaires-Survey Results. This questionnaire to ensure residents are knowledgeable of the location of the State Inspections Results Book and to identify any concerns related to assessing survey results to include but not limited to location out of reach of resident. The Social Worker and/or Activities Director will address all concerns identified during the questionnaires to include but not limited to re-education of residents and/or relocating State Inspections Results Book to meet the needs of the residents. The Administrator will review the resident questionnaires weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Activity Director will present the findings of the Resident Questionnaires-Survey Results to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Resident Questionnaires-Survey Results to determine trends and/or issues that may need further interventions put into place	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 577	Continued From page 11	F 577	and to determine the need for further frequency of monitoring.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.	F 578		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 578	Continued From page 12 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a copy of a resident's advanced directive was accessible to direct care staff for 2 of 2 residents reviewed for advanced directives (Resident #40 and Resident #41). 1. Resident #40 was admitted to the facility on 9/7/22 with diagnoses that included hypertension and chronic obstructive pulmonary disease. A physician's order dated 9/9/22 indicated Resident #40 had a status of do not resuscitate. Resident #40's admission Minimum Data Set (MDS) assessment revealed she was assessed as having moderate cognitive impairment. Record review revealed no copy of Resident #40's advanced directive was in her electronic medical record. An interview was conducted with the Administrator on 10/11/22 at 3:00 PM who stated she would locate a copy of the Resident 40's advanced directive. She stated the facility social worker was on leave. On 10/12/22 the Administrator stated Resident #40's advanced directive was in the social worker's locked office. She indicated the facility is planning to place copies of the advanced	F 578	F578 Request/Refuse/Discontinue Treatment; Formulate Adv Directive On 10/12/22, the Social worker and Assistant Director of Nursing reviewed and updated resident #40 desire for advance directive and code status. The resident care plan was updated to reflect desired advance directive and code status and the golden rod advance directive form was placed in the resident chart. On 10/11/22, the Social worker and Staff Facilitator reviewed and updated resident #41 desire for advance directive and code status. The physician was notified, and an order placed in the electronic record. The resident care plan was updated to reflect desired advance directive and code status and the golden rod advance directive form was placed in the resident chart. On 10/11/22, the Administrator and Medical Records Director initiated an audit of all resident orders for advance directive/code status. This audit is to ensure the Social Worker and/or nurse reviewed with the resident and/or resident representative the desired advance directive/code status, the physician was notified of desired advance directive/code	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 578	Continued From page 13 directives on the hard charts which are kept in the facility conference room. 2. Resident #41 was admitted to the facility on 6/29/21 with diagnoses that included dementia and epilepsy. Resident #41's annual Minimum Data Set (MDS) assessment dated 7/20/22 revealed she was assessed as cognitively intact. Record review revealed no code status indicated in Resident #41's chart. Resident #41 was not able to be interviewed. An interview was conducted with Nurse #7 on 10/11/22 at 3:15 PM. He stated Resident #41 had a full code status. Nurse #7 then checked the computer and was unable to locate Resident #41's code status. He then went into the facility conference room and returned with Resident #41's chart. Nurse #7 reviewed the chart and located Resident #41's advanced directive which indicated she had a status of do not resuscitate. He then updated Resident #41's status in the computer. On 10/12/22 the Administrator stated Resident #41's code status should have been recorded in her electronic medical record.	F 578	status, an order placed in the electronic record, the care plan updated to reflect resident desired advance directive/code status and a golden rod advance directive form was placed in the resident chart for any resident identified as requesting Do Not Resuscitate. The Social Worker and/or nurse will address all concerns identified during the audit to include notification of the physician of desired advance directive/code status and updating electronic record when indicated. The audit will be completed by 11/23/22 On 11/7/22, the Facility Consultant completed an in-service with the Social Worker, Admission Director and Director of Nursing regarding Advance Directives with emphasis on ensuring the nurse and social worker reviews advance directives with the resident and/or resident representative upon admission, notify the physician of desired advance directive/code status, obtaining an order for code status and updating the electronic record/care plan. All newly hired social workers, admission director and/or Director of Nursing will be in-serviced during orientation regarding Advance Directives. On 11/7/22, the Director of Nursing and Assistant Director of Nursing initiated an in-service with all nurses regarding Advance Directives with emphasis on reviewing advance directives with the resident and/or resident representative upon admission, notification of the physician of desired advance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 578	Continued From page 14	F 578	directive/code status, obtaining an order for code status, updating the electronic record/care plan and ensuring a golden rod advance directive form in placed in the resident chart when indicated. In-service will be completed by 11/23/22. After 11/23/22, any social worker, admission director and/or nurse who has not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired social workers, admission director and/or nurse will be in-serviced during orientation regarding Advance Directives. The Medical Records Director, Minimum Data Set Nurse, Social Worker and/or Assistant Director of Nursing will review all admissions during Interdisciplinary Team Meeting (IDT) 5 times a week x 4 weeks then monthly x 1 month utilizing the Advance Directive Audit Tool. This audit is to ensure that the Social Worker, Admission Director and/or nurse reviewed advance directive/code status with the resident and/or resident representative upon admission, the physician was notified of desired advance directive/code status, an order was placed in the electronic record and that the care plan was updated to reflect resident desired advance directive/code status. The Medical Records Director, Minimum Data Set Nurse, Social Worker and/or Assistant Director of Nursing will address all concerns identified during the audit to include reviewing resident /resident representative preference for advance directive, obtaining order when indicated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 578	Continued From page 15	F 578	and updating resident chart for desired advance directive status. The Director of Nursing will review the Advance Directive Audit Tool 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will forward the results of the Advance Directive Audit Tool to the Executive QI Committee monthly x 2 months. The Executive QI Committee will meet monthly x 2 months and review the Advance Directive Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and	F 600	F600 Free from Abuse and Neglect	11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 600	Continued From page 16 physician interview the facility failed to protect a resident's right to be free from abuse. Staff provided care on a cognitively impaired resident who was resisting and flailing her arms and legs. The resident's arm was held down while care was provided, and staff continued to provide care even when they knew it was a struggle. The resident sustained a femur (upper thigh) fracture and required surgery. This deficient practice was for 1 of 1 resident reviewed for abuse (Resident #222). Immediate Jeopardy began on 3/25/22 when NA #1 (Nursing Assistant) and NA #2 provided care to Resident #222 when the resident was resistant, and the resident sustained a right femur fracture. Immediate Jeopardy was removed on 10/15/22 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place are effective and to complete employee in-service training. Findings Included: A review of Resident #222's closed record revealed she was admitted to the facility on 2/16/22. Her diagnoses included dementia, hypertension, glaucoma, psychotic disturbance, mood disturbance, anxiety, and anemia. The Admission Minimum Data Set (MDS) dated 2/22/22 revealed Resident #222 had severe cognitive impairment. She required extensive assistance with bed mobility and total assistance with toilet use. The MDS indicated Resident #222	F 600	Resident #222 no longer resides in the facility. On 03/25/22, the DON initiated an audit of all residents not able to report for signs and symptoms of a fracture including bruising, pain, swelling, skin tears. Audit was completed on 03/25/22 with no additional concerns identified. On 03/25/22 the Register Nurse (RN) Supervisor interviewed all alert and oriented residents regarding: Have you sustained any injury that has not been reported to staff? The assigned nurse will address all concerns identified during the questionnaires. Questionnaires were completed on 03/28/22 with no additional concerns identified. On 03/28/22, the DON initiated Staff Quiz with all therapy staff, nurses and nursing assistants to include agency regarding Abuse/Combative /Aggressive Residents. This quiz is to validate staff knowledge on abuse/combative/aggressive residents to include reporting abuse/combative/ aggressive behaviors and leaving resident in a safe manner when abuse/combative/ aggressive and attempting care when calm. Quizzes will be completed by 3/28/22. After 3/28/22, After 3/28/22, the Receptionist will mail quiz to any therapy staff, nurse or nursing assistant who has not worked or who has not received the quiz with instructions to complete, sign and return to the DON prior to next scheduled shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 600	Continued From page 17 did not have behaviors. Resident #222 was care planned on 2/17/22 for problematic manner in which resident acts characterized by inappropriate behavior; resistive to treatment/care related to: argumentative, aggressive, combative to staff during care. The goal included will receive care within resident's choices and preferences through next review. Interventions included the following: o Allow for flexibility in ADL routine to accommodate resident's mood. o Document care being resisted per facility protocol and notify physician of patterns in behavior. o Elicit family input for best approaches to resident o If resident refuses care, re-attempt at another time. o Provide non-care related conversation proactively before attempting ADL Record review revealed the following nurses note by the former Director of Nursing on 3/25/22 at 8:35 PM: Approximately 12:46 PM Nurse #5 came to my office stating that the resident leg is swollen, and it was not like that this morning on her assessment. I went to the resident's room and the resident bed was noted to be pulled out of the wall at the foot of the bed. The therapy director was standing on the right side of the bed against the wall. Occupational Therapy and the charge nurse were standing on the left side of the bed. The resident was laying on her back with her right foot partially off the bed. The resident left leg was on the bed. The resident left thigh appeared	F 600	On 4/22/22, a mandatory in-service was completed with the attendance of the Administrator, and Director of Nursing regarding reportable allegations including to always ensure the involved resident and all other residents are safe and protected first, removing the alleged perpetrator, placing the perpetrator in a non-resident care area, if the perpetrator is another resident supervise the resident until details of the incident can be determined and appropriate interventions initiated, assessment of the resident and reporting within a 2 hour time frame. On 6/16/22, a Town Hall meeting was held by the Administrator with nurses, nursing assistants, therapy staff, housekeeping, dietary staff, social worker, accounts receivable/payable, receptionist, maintenance and admission staff regarding Abuse to include removing identified staff immediately to protect the resident and reporting abuse. On 03/28/22 the DON initiated in-service with all therapy staff, nurses and nursing assistants to include agency in regards to (1) Abuse (2) Combative Residents with emphasis on making sure resident is safe and leave resident to calm down then re-approach for care, (3) Turning and Positioning with care with emphasis on technique for turning and positioning, (4) Signs and Symptoms of a fracture with emphasis on identifying signs/symptoms of a fracture and immediately reporting symptoms to nursing (5) Safe Handling	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 600	Continued From page 18	F 600		

swollen and warm to touch. No discoloration, bruising or redness noted. Her skin color to her right thigh was in normal limits with the rest of her body. The resident was attempting to move her leg. I informed the patient several times while in the room not to move her leg, we needed to send her to the emergency room for evaluation. While in the room the resident did not appear to be in pain, she was answering questions but was becoming agitated when asked about her leg. She stated, "you see my leg don't you". I asked her what happened to her leg, and she stated she did not know what happened to her leg, but something was wrong with it. I asked her did anyone hurt her, and she stated, "no". Resident was left with nurse so I could notify the MD and receive an order for transport to emergency department. Physician notified and stated ok to send to emergency department.

A second note by the former DON dated 3/28/22 at 3:25 PM read as follows: Correction the resident's right thigh appeared swollen. Her left leg was within normal limits.

A telephone interview was conducted with NA#1 on 10/14/22 at 9:12 AM. She stated she went to provide incontinence care to Resident #222 on 3/25/22. She stated Resident #222 was resistant and was flailing both her arms and legs. She stated she stopped and went into the hall and asked someone to come help her. NA #1 stated the whole thing was a struggle. She stated NA#2 came in the room to assist and her and NA#2 tried to be careful and keep Resident #222 safe. She stated NA#2 adjusted the bed away from the wall and positioned herself at the head of the bed. NA#1 stated NA#2 held one of Resident #222's arm to keep her from moving and hurting herself

with emphasis on checking care guide prior to providing care to ensure safety of the resident and (6) Pain with emphasis on immediately reporting pain with care to the nurse for pain management.
In-services will be completed by 3/28/22. After 3/28/22, the Receptionist will mail in-services to any therapy staff, nurse or nursing assistant who has not worked or who has not received the in-service with instructions to read, sign and return to the DON prior to next scheduled shift. All newly hired therapy staff, nurse or nursing assistant to include agency will be in-serviced during orientation regarding Combative Residents, Turning and Positioning, Signs and Symptoms of a Fracture, Safe Handling and Pain.
On 10/14/22, an in-service was initiated by the Administrator with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and receptionist regarding Burn Out, Abuse. The in-service included the definition of physical abuse and the consequences if found guilty of abuse. In-services to be completed by 10/14/22. After 10/14/22, any employee who has not completed the training will not be allowed to work until completion.
The Director of Nursing and Assistant Director of Nursing will complete 10 staff quizzes regarding Abuse/Combative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 600	Continued From page 19	F 600		

while she continued to give care. NA#1 stated even though Resident #222 was combative, they still tried to give care. She reported there was a lot of fighting and resisting and Resident #222 was moving both her arms and her legs. NA#1 stated when they rolled Resident #222 over on her back was when she noticed a deformity in her leg, and she went to get a nurse. NA#1 stated NA#2 and well as herself were from an agency and did not work for the facility.

Attempts made to contact NA#2 were unsuccessful.

Nurse #5 was interviewed on 10/14/22 at 11:00 AM. She stated she was the nurse caring for Resident #222 on 3/25/22. Nurse #5 reported she left for lunch and when she came back, she could hear Resident #222 saying "go get the nurse" so she went to her room. Nurse #5 stated she entered Resident #222's room and noticed her right leg laterally rotated towards the right. She stated she evaluated patient leg/femur and it was swollen and hot to the touch. Resident #222 yelled out in pain and stated, "this bitch broke my leg" and "she was yanking on it." Nurse #5 stated NA#1 was in Resident #222's room and that's who she was talking about. Nurse #5 stated she left the room to go get the former DON to come to the room. She reported she went to the nurses' station to get the paperwork ready for Resident #222 to be sent to the hospital.

On 10/14/22 at 10:15 AM a telephone interview was conducted with Therapist #1. She stated she was in a nearby room and could hear Resident #222 loudly calling for help. She stated she went into the room and saw NA#1 and NA#2 and noticed Resident #222's leg was displaced. She

Residents weekly x 4 weeks then monthly x 1 month. This quiz is to validate staff knowledge and understanding of the education/in-services on abuse/combative residents and management of combative residents to include but not limited to stopping care immediately for residents who are combative, never restraining a resident who is combative to provide care, ensure safety of resident and re-approach when calm. Any staff who does not demonstrate knowledge and understanding of education will be re-educated by the Director of Nursing and Assistant Director of Nursing and will complete a follow up quiz. The Administrator will review the quizzes weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.

The Interdisciplinary team to include minimum data set nurse (MDS), Assistant Director of Nursing (ADON) and Unit Managers will review progress notes 5 days a week x 4 weeks then monthly x 1 month using the Behavior Audit Tool. This audit is to identify any residents with aggressive and/or combative behaviors to ensure that staff followed protocol when dealing with combative residents to include stopping care immediately for residents who are combative, never restraining a resident who is combative to provide care, ensure safety of resident and re-approach when calm. The MDS nurse, ADON and/or Unit Managers will address all concerns identified during the audit to include but not limited to assessing the resident, initiating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 600	Continued From page 20	F 600		

stated she heard the NA's say they were providing care and the resident was agitated. Therapist #1 stated she was holding Resident 222's hand trying to comfort her. She stated she didn't hear Resident #222 say what happened to her leg.

An interview was conducted with the Rehab Director on 10/14/22 at 10:05 AM and she stated Therapist #1 texted her and said she needed her in Resident #222's room. The Rehab Director stated Therapist #1 heard Resident #222 screaming and went into her room. The Rehab Director stated she saw the right upper leg was deformed and she got Nurse #1 and the former DON. She stated Resident #222 allowed her to hold her hand to try and comfort her before she left the room. The Rehab Director stated Resident #222 did not say what had happened to her leg.

Nurse #1 was interviewed on 10/14/22 at 10:00 AM and he reported he went into Resident #222's room and looked at her leg and went to get the former DON. He stated she came to the room and took over and he left.

On 10/13/22 at 5:05 PM a telephone interview was conducted with the former Director of Nursing (DON). She stated what she remembered about the incident involving Resident #222 was NA #1 went in to give Resident #222 a bath and she was combative. She stated she was told by NA#1 Resident #222 was flailing her arms and legs. She stated NA#1 stopped care and went into the hall and got help. NA#2 went into the room to assist with the bath. The former DON reported she was told when Resident #222 was rolled on her back they

interventions when indicated, notification of the physician for further recommendations and re-training of staff regarding dealing with combative residents. The DON will review the Behavior Audit Tool 5 days a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed.

The Administrator will present the findings of the Abuse/Combative Resident Quiz and Behavior Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Abuse/Combative Resident Quiz and Behavior Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 600	Continued From page 21	F 600		

noticed her leg had a deformity and they went to get Nurse #1 and after he looked at Resident #222's leg he went and got and her. She stated when she entered Resident #222's room she observed Resident #222's right leg externally rotated and swollen. She stated she assessed Resident #222 with no bruising or abrasions. The former DON stated she didn't know if Resident #222 was still combative when NA#2 went into the room.

The discharge summary from a local hospital for Resident #222 was reviewed. Resident #222 was admitted to the hospital on 3/25/22. A computerized tomography (CT) scan was completed on 3/25/22 and revealed Resident #222 had a stable displaced acute distal femoral (upper leg) fracture. On 3/26/22 she had open treatment of the right femoral shaft with insertion of nail and screws. The discharge summary indicated Resident #222 received physical and occupational therapy and was weight bearing as tolerated.

On 10/14/22 at 11:18 AM and interview was conducted with Resident 222's Physician. She stated Resident #222 had advanced dementia and she could be pleasant but on exam, proving care, and providing incontinent care Resident #222 could get combative waving arms about and legs. The Physician stated she went to Resident #222's room and saw the deformity. She reported Resident #222 was hollering in pain.

On 10/14/22 at 2:54 PM an Interview was conducted with the Administrator, and she stated when she found out what had occurred the ambulance was still outside with Resident #222 in the back. She stated she ran outside and spoke

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 600	Continued From page 22	F 600		

with Resident #222. The Administrator reported she asked Resident #222 if anyone hurt her, touched her, or harmed her and she responded no. The administrator stated she never had any concerns for abuse based on what Resident #222 reported.

The facility was notified of the Immediate Jeopardy on 10/14/22 at 2:24 PM.

The facility provided the following credible allegation for abuse.

Credible Allegation-F 600 Abuse

" Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

Resident is alert to self with confusion. Brief Interview for Mental Status (BIMS) is 4. Diagnoses include Dementia without behavioral, Cellulitis of left lower limb, Hypertension, Anemia, disturbance, Glaucoma, Pressure ulcer of left heel Unstageable, Chronic kidney disease, Urinary tract infection, Uterovaginal prolapse, Bacteremia and osteoarthritis. The resident was able to make her needs known. On 03/25/22 at, 12:15 pm nursing assistant (NA) #1 entered resident room to provide incontinent care. Resident # 222 was agitated and declined care. On 03/25/22 at 12:20pm, NA #2 heard resident yell "ouch". NA #1 came out and asked NA #2 for assistance with incontinent care. NA#1 and NA #2 returned to the resident room to provide care. The bed was positioned slightly away from the wall. Resident was lying on right side with brief off and legs positioned slightly off the bed on the right side. NA #2 adjusted the bed slightly further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 600	Continued From page 23	F 600		

away from the wall and positioned self at head of resident bed to assist with care. At no time during the conversation with the nurse did the resident identify a specific individual or specific event. On 3/25/22 at approximately 12:46 pm, the Director of Nursing (DON) notified of potential injury to Resident # 222. DON entered resident room and observed resident right leg externally rotated and swollen. DON assessed resident with no bruising or abrasions noted. Resident stated, "nothing happened, and no one has hurt me, I don't know what is wrong with it" and attempted to move right leg from side to side. On 3/25/22 at 12:46 pm, the DON notified the physician of potential injury to Resident # 222 with new order to transfer to the emergency room for evaluation and treatment.
On 3/25/22 at approximately 12:46 pm, Emergency Medical Services (EMS) notified to transport Resident # 222 to the emergency room for evaluation and treatment. On 3/25/22, the assigned nurse informed the resident representative (RR) of pain and swelling of Resident # 222's right thigh and that resident was being sent to the emergency room (ER) for evaluation. On 03/25/22 at 12:48 pm, the Administrator notified of potential injury to Resident # 222. On 3/25/22 at approximately 1:00 pm, EMS transported Resident # 222 to the emergency room for evaluation and treatment.
On 3/25/22 the Administrator completed and faxed the Initial Report to the Health Care Personnel Investigation Unit related injury of unknown origin. On 3/31/22, the Administrator completed and faxed the Investigation Report to the Health Care Personnel Investigation Unit related injury of unknown origin.
On 03/25/22, the DON initiated an audit of all residents not able to report for signs and symptoms of a fracture including bruising, pain,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 600	Continued From page 24	F 600		

swelling, skin tears. Audit was completed on 03/25/22 with no additional concerns identified. On 03/25/22 the Register Nurse (RN) Supervisor interviewed all alert and oriented residents regarding: Have you sustained any injury that has not been reported to staff? The assigned nurse will address all concerns identified during the questionnaires. Questionnaires were completed on 03/28/22 with no additional concerns identified.

" Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 03/28/22, the DON initiated Staff Quiz with all therapy staff, nurses and nursing assistants to include agency regarding Combative /Aggressive Residents. This quiz is to validate staff knowledge on combative/aggressive residents to include reporting combative/ aggressive behaviors and leaving resident in a safe manner when combative/ aggressive and attempting care when calm. Quizzes will be completed by 3/28/22. After 3/28/22, After 3/28/22, the Receptionist will mail quiz to any therapy staff, nurse or nursing assistant who has not worked or who has not received the quiz with instructions to complete, sign and return to the DON prior to next scheduled shift.

On 4/22/22, a mandatory in-service was completed with the attendance of the Administrator, and Director of Nursing regarding reportable allegations including to always ensure the involved resident and all other residents are safe and protected first, removing the alleged perpetrator, placing the perpetrator in a non-resident care area, if the perpetrator is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 600	Continued From page 25	F 600		

another resident supervise the resident until details of the incident can be determined and appropriate interventions initiated, assessment of the resident and reporting within a 2 hour time frame.

On 6/16/22, a town hall meeting was held by the Administrator with nurses, nursing assistants, therapy staff, housekeeping, dietary staff, social worker, accounts receivable/payable, receptionist, maintenance and admission staff regarding Abuse to include removing identified staff immediately to protect the resident and reporting abuse.

On 03/28/22 the DON initiated in-service with all therapy staff, nurses and nursing assistants to include agency in regards to (1) Combative Residents with emphasis on making sure resident is safe and leave resident to calm down then re-approach for care, (2) Turning and Positioning with care with emphasis on technique for turning and positioning, (3) Signs and Symptoms of a fracture with emphasis on identifying signs/symptoms of a fracture and immediately reporting symptoms to nursing (4) Safe Handling with emphasis on checking care guide prior to providing care to ensure safety of the resident and (5) Pain with emphasis on immediately reporting pain with care to the nurse for pain management. In-services will be completed by 3/28/22. After 3/28/22, the Receptionist will mail in-services to any therapy staff, nurse or nursing assistant who has not worked or who has not received the in-service with instructions to read, sign and return to the DON prior to next scheduled shift. All newly hired therapy staff, nurse or nursing assistant to include agency will be in-serviced during orientation regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 600	Continued From page 26	F 600		

Combative Residents, Turning and Positioning, Signs and Symptoms of a Fracture, Safe Handling and Pain.

On 10/14/22, an in-service was initiated by the Administrator with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and receptionist regarding burn out, abuse. The in-service included the definition of physical abuse and the consequences if found guilty of abuse. In-services to be completed by 10/14/22. After 10/14/22, any employee who has not completed the training will not be allowed to work until completion.

Date of credible allegation of immediate jeopardy removal was competed on 10/15/22.

On 10/15/22 the credible allegation of immediate jeopardy removal was validated by onsite verification. Record review indicated an in-service was completed on 10/14/22 with 100% staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and receptionist regarding burn out, abuse, definition of abuse, and consequences of abuse of found guilty. A review of the in-service sign-in sheets as well as staff interviews conducted on 10/15/22 verified education was provided on abuse. After

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 600	Continued From page 27 10/14/22, any employee who has not completed the training will not be allowed to work until completion. The facility's immediate jeopardy removal date of 10/15/22 was verified.	F 600		
F 609 SS=B	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 609	Continued From page 28 by: Based on record review and staff interviews, the facility failed to 1) report to the state regulatory agency an incident related to injury of unknown cause (Resident #222) within the two-hour time frame and 2) complete and submit an accurate investigation report within five days to the state regulatory agency for diversion of facility drugs (Resident #174) for 2 of 2 residents reviewed in facility reported incidents. Findings included: 1. Resident #222 was admitted to the facility on 2/16/22. Her diagnoses included dementia. The Admission Minimum Data Set (MDS) dated 2/22/22 revealed Resident #222 had severe cognitive impairment. A review of Resident #222's medical record revealed Resident #222 sustained a deformity to her right upper leg after receiving care on 3/25/22 at approximately 12:45 PM. A review of the initial facility reported incident regarding Resident #222 revealed the report was faxed to the state regulatory agency on 3/15/22 at 4:52 PM. An interview was conducted with the Administrator on 10/14/22 at 4:12 PM, and she stated she became aware of the incident involving Resident #222 right after it happened which was approximately 12:45 PM. She stated the report for injury of unknown cause for Resident #222 should have been sent to the state agency within the regulatory time frame of 2 hours. The administrator was unable to explain why the report was faxed in late.	F 609	F609 Reporting of Alleged Violations Resident #222 no longer resides in the facility. Initial report was submitted to the state regulatory agency on 3/15/22 at 4:52pm Investigative Report for resident #174 was faxed to the state regulatory agency on 12/22/21. On 11/7/22, the facility consultant initiated an audit of all events that meet criteria for reporting to the Health Care Personnel Investigations (HCPI) state regulatory agency for the past 30 days to include but not limited to injury of unknown origin, misappropriation and/or abuse. This audit is to ensure all reportable events were reported within the two-hour time frame when indicated and that the facility submitted an accurate investigation report within 5 days per the HCPI requirements. The facility consultant and Administrator will address all concerns identified during the audit to include but not limited completion of initial and investigative reports when indicated and education of staff. The audit will be completed by 11/23/22. On 11/7/22, the facility consultant initiated an in-service with the Administrator and Director of Nursing regarding Health Care Personnel Investigation Reportable Requirements with emphasis on reporting allegations to include but not limited to injury of unknown, misappropriation and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 609	Continued From page 29 2. Resident #174 was admitted to the facility on 11/23/2021 with diagnoses including chronic pain. Resident #174 was discharged from the facility on 11/30/2021. Physician orders dated 11/23/2021 revealed Resident #174 was ordered Oxycodone-Acetaminophen 7.5-325 milligrams 1 tablet orally every four hours as needed for pain. A review of the November 2021 Medication Administration Record revealed Resident #174 received Oxycodone-Acetaminophen 7.5-325 milligrams 1 tablet last on 11/30/2021 at 5:37 a.m. A review of a written statement dated 12/13/2021 by Nurse #8 revealed when preparing to return Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets to the pharmacy on 12/13/2021, Nurse #8 observed two loose tablets in the package. Nurse #8 stated sixty-eight Oxycodone-Acetaminophen 7.5-325 milligrams tablets were verified and the narcotic sheet reflected seventy-two Oxycodone-Acetaminophen 7.5-325 milligrams tablets pills. He stated the DON was notified and returned to the facility to further investigate. A review of the initial report dated 12/13/2021 at 8:47 p.m. revealed there were four tablets of Oxycodone-Acetaminophen 7.5-325 milligrams discovered missing from Resident #174 medications. The initial report was dated faxed to the state regulatory agency on 12/14/2021 at 12:12 p.m. A review of the investigation report revealed the investigation report was faxed to the state regulatory agency on 12/22/2021 at 12:30p.m.	F 609	abuse within 2 hours when indicated and completion of an accurate investigation report within 5 days per HCPI requirements. In-service will be completed by 11/23/22. All newly hired Administrators and/or Director of Nursing will be in-serviced during orientation regarding Health Care Personnel Investigation Reportable Requirements. The Admission Director and Assistant Director of Nursing will review all investigative folders weekly x 4 weeks then monthly x 1 month utilizing the HCPI Audit Tool. This audit is to ensure all HCPI reportable events to include injury of unknown origin, misappropriation and/or abuse are reported timely and an accurate investigative report completed within 5 days per HCPI requirements. The Admission Director and Assistant Director of Nursing will address all areas of concern identified during the audit to include reporting initial and investigative reports when indicated and re-training of staff. The facility consultant or corporate leadership will review and initial the HCPI Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will present the findings of the HCPI Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the HCPI Audit Tool to determine trends and/or issues that may	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 609	Continued From page 30 The investigation report indicated an investigation was initiated that included reporting the incident to local law enforcement, auditing of all medication carts and narcotic storage boxes, nursing education on returning controlled substances to pharmacy, reviewing thirty days of reports from pharmacy to evaluate discrepancy in control substances and drug testing all nursing staff potentially involved. The investigation report stated the investigation was ongoing due to awaiting drug testing results from all staff potentially involved and indicated the allegation was not substantiated and no termination of an employee. On 10/14/2022 in an interview with the Administrator, she stated a diversion of four tablets was determined substantiated for Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets, and the investigation report should not indicate the allegation was not substantiated and no termination of an employee. She stated she answered the questions on the investigation report "no" based on the facility was still waiting results of the drug test. She stated the investigation report should had been reported within five working days indicating the investigation was ongoing without answering the questions whether the allegation was substantiated and termination of an employee and submitted a finalized investigation report upon completion of the investigation.	F 609	need further interventions put into place and to determine the need for further frequency of monitoring.	
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 610	Continued From page 31 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to protect residents when NA #1 and NA #2 were not removed from resident care assignments after an allegation of abuse with Resident #222. NA #1 and NA #2 continued to provide resident care. This had the high likelihood to put other residents at high risk for abuse and harm. The facility also failed to conduct a thorough investigation. Immediate jeopardy began on 3/25/22 when the facility allowed NA #1 and NA #2 to continue working after Resident #222 stated, "That bitch broke my leg" and "She was yanking on it." The immediate jeopardy was removed on 10/15/22 when the facility implemented a credible allegation of jeopardy removal. The facility will remain out of compliance at a lower scope and severity D to ensure monitoring systems are put into place and are effective to complete employee in-service training.	F 610	F610 Investigate/Prevent/Correct alleged violation Resident #222 no longer resides in the facility. On 3/25/22 the Administrator completed and faxed the Initial Report to the Health Care Personnel Investigation Unit related injury of unknown origin. On 3/31/22, the Administrator completed and faxed the Investigation Report to the Health Care Personnel Investigation Unit related injury of unknown origin. The nursing assistant (NA) #1 and nursing assistant #2 were not removed from the floor following the incident. However, NA #1 and NA #2 did not return to work after their shift, pending the investigation There were no other allegations of injury of unknown origin or allegations of abuse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 610	Continued From page 32 Findings Included: Resident #222 was admitted to the facility on 2/16/22. Her diagnoses included dementia. The Admission Minimum Data Set (MDS) dated 2/22/22 revealed Resident #222 had severe cognitive impairment. She required extensive assistance with bed mobility and transfers occurred once or twice. Total assistance was needed for toilet use and supervision for eating. The MDS indicated Resident #222 had no rejection of care. Record review revealed the following nurses note by the Director of Nursing (DON) #2 on 3/25/22 at 8:35 PM: Approximately 12:46 PM Nurse #5 came to my office stating that the resident leg is swollen, and it was not like that this morning on her assessment. I went to the resident's room and the resident bed was noted to be pulled out of the wall at the foot of the bed. The therapy director was standing on the right side of the bed against the wall. Occupational Therapy and the charge nurse were standing on the left side of the bed. The resident was laying on her back with her right foot partially off the bed. The resident left leg was on the bed. The resident left thigh appeared swollen and warm to touch. No discoloration, bruising or redness noted. Her skin color to her right thigh was in normal limits with the rest of her body. The resident was attempting to move her leg. I informed the resident several times while in the room not to move her leg, we needed to send her to the emergency room for evaluation. While in the room the resident did not appear to be in pain, she was answering questions but was	F 610	in the past 30 days that identified an employee. On 3/28/22, the Interdisciplinary team reviewed concerns and acute changes from 3/25/22 to 3/27/22 including allegations of abuse and injury of unknown origin with no concerns identified. On 4/22/22, a mandatory in-service was completed with the attendance of the Administrator, and Director of Nursing regarding reportable allegations including possible abuse, and notification to the Regional Vice President and Facility Consultant to always ensure the involved resident and all other residents are safe and protected first, removing the alleged perpetrator, placing the perpetrator in a non-resident care area, if the perpetrator is another resident, supervise the resident until details of the incident can be determined and appropriate interventions initiated, assessment of the resident and reporting within a 2 hour time frame. On 6/16/22, a town hall meeting was held by the Administrator with nurses, nursing assistants, therapy staff, housekeeping, dietary staff, social worker, accounts receivable/payable, receptionist, maintenance and admission staff regarding Abuse to include removing identified staff immediately to protect the resident and reporting abuse. On 10/14/22, an in-service was initiated by the Administrator with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 610	Continued From page 33	F 610		

becoming agitated when asked about her leg. She stated, "You see my leg don't you". I asked her what happened to her leg, and she stated she did not know what happened to her leg, but something was wrong with it. I asked her did anyone hurt her, and she stated, "no." Resident was left with nurse so I could notify the MD and receive an order for transport to emergency department. Physician notified and stated ok to send to emergency department.

A second note by the DON #1 dated 3/28/22 at 3:25 PM read as follows: Correction the resident's right thigh appeared swollen. Her left leg was within normal limits.

Record review revealed on 3/31/22 the facility sent their investigation report on Resident #222 for an injury of unknown cause to the state survey agency. The report indicated Adult Protective Services and law enforcement were notified of the incident. The facility reported incident was unsubstantiated for injury of unknown cause. The summary of the facility investigation read as follows: Resident #222 was unable to tell what occurred when asked. Resident #222 reported that she was up walking around cleaning. Resident #222 was unable to walk around without assistance and had not been cleaning. Resident #222 did not report any abuse per Administrator interview in the presence of 2 Emergency Medical Services personnel. Resident #222 replied, "No" when asked if anyone hurt or harmed her.

Nurse #5 was interviewed on 10/14/22 at 11:00 AM. She stated she was the nurse caring for Resident #222 on 3/25/22. Nurse #5 reported she left for lunch and when she came back, she could hear Resident #222 saying "go get the

housekeeping staff, therapy staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and receptionist regarding burn out, abuse and what to do when residents display aggressive behaviors. The in-service included the definition of physical abuse and the consequences if found guilty of abuse. In-services to be completed by 10/14/22. After 10/14/22, any employee who has not completed the training will not be allowed to work until completion.

The Assistant Director of Nursing and Admission Director will review all investigative folders to include but not limited to investigative folders for the past 30 days regarding abuse, neglect, exploitation, mistreatment and/or injury of unknown origin weekly x 4 weeks then monthly x 1 month utilizing the HCPI Audit Tool. This audit is to ensure alleged violations are thoroughly investigated and that the facility initiated interventions immediately to prevent further potential abuse, neglect, exploitation or mistreatment while the investigation is in progress to include but not limited to immediate removal of any staff identified during the investigation from resident care assignments. The Assistant Director of Nursing and Admission Director will address all areas of concern identified during the audit to include completing a thorough investigation, initiating interventions to prevent further potential

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 610	Continued From page 34 nurse" so she went to her room. Nurse #5 stated she entered Resident #222's room and noticed her right leg laterally rotated towards the right. She stated she evaluated patient leg/femur and it was swollen and hot to the touch. Resident #222 yelled out in pain and stated, "This bitch broke my leg" and "she was yanking on it." Nurse #5 stated NA #1 was in Resident #222's room and that's who she was talking about. Nurse #5 stated she left the room to go get the DON #1 to come to the room. She reported she went to the nurses' station to get the paperwork ready for Resident #222 to be sent to the hospital. On 10/14/22 at 2:54 PM an interview was conducted with the Administrator, and she stated when she found out what had occurred the ambulance was still outside with Resident #222 in the back. She stated she ran outside and spoke with Resident #222. The Administrator reported she asked Resident #222 if anyone hurt her, touched her, or harmed her and she responded no. An interview was conducted with NA#1 on 10/14/22 04:21 PM. She stated after the incident with Resident #222 she went back to work and provided care for other residents in the facility. Attempts made to contact NA#2 were unsuccessful. An interview was conducted with the Administrator on 10/14/22 at 4:12 PM, and she stated she interviewed Resident #222 while she was in the ambulance about to leave for the hospital on 3/25/22. She stated Resident #222 reported to her no one hurt her, touched, or harmed her. She had no concerns regarding	F 610	abuse, neglect, exploitation or mistreatment while the investigation is in progress to include immediate removal of any staff identified during the investigation from resident care assignments and re-training of staff. The Facility Consultant and/or corporate leadership will review and initial the HCPI Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will present the findings of the HCPI Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the HCPI Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 610	Continued From page 35	F 610		

abuse based on what Resident #222 reported to her. She stated an investigation was not conducted regarding abuse, but an investigation was completed regarding an injury of unknown cause. The Administrator stated she did not believe abuse based on what Resident #222 had stated. The Administrator reported NA#1 and NA#2 were not sent home after the incident and they continued to provide care to other residents in the facility for the remainder of their 8-hour shift. The Administrator stated had abuse been a concern, NA#1 and NA#2 would have been escorted out of the building and an abuse investigation would have been conducted.

The facility was notified of the immediate jeopardy on 10/14/22 at 3:57 PM.

The facility provided the following credible allegation of immediate jeopardy removal.

" Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

Resident is alert to self with confusion. Brief Interview for Mental Status (BIMS) is 4. Diagnoses include Dementia without behavioral, Cellulitis of left lower limb, Hypertension, Anemia, disturbance, Glaucoma, Pressure ulcer of left heel Unstageable, Chronic kidney disease, Urinary tract infection, Uterovaginal prolapse, Bacteremia and osteoarthritis. The resident was able to make her needs known. On 03/25/22 at, 12:15 pm nursing assistant (NA) #1 entered resident room to provide incontinent care. Resident # 222 was agitated and declined care. On 03/25/22 at 12:20 pm, NA #2 heard resident yell "ouch". NA #1 came out and asked NA #2 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 610	Continued From page 36	F 610		

assistance with incontinent care. NA#1 and NA #2 returned to the resident room to provide care. The bed was positioned slightly away from the wall. Resident was lying on right side with brief off and legs positioned slightly off the bed on the right side. NA #2 adjusted the bed slightly further away from the wall and positioned self at head of resident bed to assist with care. The resident was agitated, failing arms and yelling. Resident hit NA #2 in the chest when failing arms so NA#2 held the resident 's hands while NA#1 provided incontinent care. After the incontinent care provided, NA #1 and NA #2 rolled resident back to supine (lying face upward) position using draw sheet. Left leg landed onto the bed in an anatomically correct position. The right leg was rotated to the right from the knee downward and positioned slightly off to the right side of the bed. NA #2 noticed swelling and abnormal position of leg. NA #1 and NA #2 stopped care. NA #2 left room to notify the nurse. On 3/25/22 at 12:45pm, Nurse #1 entered resident room and noted right leg laterally rotated towards the right. The nurse evaluated patient leg/femur noted to be swollen and hot to the touch. Patient yelled out in pain. The resident stated, "this bitch broke my leg". At no time during the conversation with the nurse did the resident identify a specific individual or specific event. On 3/25/22 at approximately 12:46 pm, the Director of Nursing (DON) notified of potential injury to Resident # 222. DON entered resident room and observed resident right leg externally rotated and swollen. DON assessed resident with no bruising or abrasions noted. Resident stated, "nothing happened, and no one has hurt me, I don't know what is wrong with it" and attempted to move right leg from side to side. On 3/25/22 at 12:46 pm, the DON notified the physician of potential injury to Resident # 222 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 610	Continued From page 37	F 610		

new order to transfer to the emergency room for evaluation and treatment. On 3/25/22 at approximately 12:46 pm, Emergency Medical Services (EMS) notified to transport Resident # 222 to the emergency room for evaluation and treatment. On 3/25/22, the assigned nurse informed the resident representative (RR) of pain and swelling of Resident # 222's right thigh and that resident was being sent to the emergency room (ER) for evaluation. On 03/25/22 at 12:48 pm, the Administrator notified of potential injury to Resident # 222. On 3/25/22 at approximately 1:00 pm, EMS transported Resident # 222 to the emergency room for evaluation and treatment. On 3/25/22 the Administrator completed and faxed the Initial Report to the Health Care Personnel Investigation Unit related injury of unknown origin. On 3/31/22, the Administrator completed and faxed the Investigation Report to the Health Care Personnel Investigation Unit related injury of unknown origin. The nursing assistant (NA) #1 and nursing assistant #2 were not removed from the floor following the incident. However, NA #1 and NA #2 did not return to work after their shift, pending the investigation

There were no other allegations of injury of unknown origin or allegations of abuse in the past 30 days that identified an employee. On 3/28/22, the Interdisciplinary team reviewed concerns and acute changes from 3/25/22 to 3/27/22 including allegations of abuse and injury of unknown origin with no concerns identified.

" Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 610	Continued From page 38	F 610		

On 4/22/22, a mandatory in-service was completed with the attendance of the Administrator, and Director of Nursing regarding reportable allegations including possible abuse, and notification to the Regional Vice President and Facility Consultant to always ensure the involved resident and all other residents are safe and protected first, removing the alleged perpetrator, placing the perpetrator in a non-resident care area, if the perpetrator is another resident supervise the resident until details of the incident can be determined and appropriate interventions initiated, assessment of the resident and reporting within a 2 hour time frame.

On 6/16/22, a town hall meeting was held by the Administrator with nurses, nursing assistants, therapy staff, housekeeping, dietary staff, social worker, accounts receivable/payable, receptionist, maintenance, and admission staff regarding Abuse to include removing identified staff immediately to protect the resident and reporting abuse.

On 10/14/22, an in-service was initiated by the Administrator with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and receptionist regarding burn out, abuse and what to do when residents display aggressive behaviors. The in-service included the definition of physical abuse and the consequences if found guilty of abuse. In-services to be completed by 10/14/22. After 10/14/22, any employee who has not completed the training will not be allowed to work until completion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 610	Continued From page 39 Date of Corrective Action Completion 10/15/22 On 10/15/22 the credible allegation of immediate jeopardy removal was validated by onsite verification. Record review indicated an in-service was completed on 10/14/22 with 100% staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and receptionist regarding burn out, abuse, definition of abuse, and consequences of abuse of found guilty. A review of the in-service sign-in sheets as well as staff interviews conducted on 10/15/22 verified education was provided on abuse. After 10/14/22, any employee who has not completed the training will not be allowed to work until completion. The facility's immediate jeopardy removal date of 10/15/22 was verified.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 656	Continued From page 40 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews the facility failed to develop and implement an individualized person-center care plan for 2 of 20 residents reviewed for care plans (Resident #47 and Resident #30). 1. Resident #47 was admitted to the facility on	F 656	F656 Develop/Implement Comprehensive Care Plan Resident #47 no longer resides in the facility. On 10/10/22, the Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 656	Continued From page 41 9/5/22 with diagnoses including flaccid neuropathic bladder and atrial fibrillation. The admission Minimum Data Set (MDS) dated 9/11/22 indicated Resident #47 had moderate cognitive impairment, required assistance with activities of daily living and had an indwelling urinary catheter. A review of care plans for Resident #47 revealed no plan had been developed for urinary catheter care. On 10/10/22 at 12:11 PM Resident #47 was interviewed. He stated he has had a urinary catheter since admission. Nurse #9 was interviewed on 10/12/22 at 11:48 AM and she reported Resident #47 had an indwelling urinary catheter. An interview with the MDS Nurse was conducted on 10/12/22 at 1:41 PM. She reported Resident #47 had an indwelling urinary catheter which was noted on the admission MDS assessment dated 9/11/22. She stated she should have initiated a care plan and it was missed. 2. Resident #30 was admitted to the facility on 4/21/21. Resident #30's most recent Minimum Data Set (MDS) assessment dated 8/29/22 revealed she was cognitively intact. Resident #30's active care plan (initiated on 08/24/21) revealed she was care planned as a smoker who needed staff supervision. Smoking assessments dated 11/01/21, 2/1/22,	F 656	updated the smoking assessment for resident #30. Resident was identified as a supervised smoker. The care plan was reviewed and accurately reflects resident smoking status. On 10/19/22, the MDS Consultant and Director of Nursing initiated an audit of all resident care plans to ensure the care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident□s medical, nursing, and mental/psychosocial needs to include but not limited to foley care and smoking status. The MDS Consultant will address all concerns identified during the audit to include assessment of resident for safety when smoking, need for foley care and updating care plan when indicated. The audit will be completed by 11/23/22 On 11/7/22, the Assistant Director of Nursing and Director of Nursing initiated an in-services with all nurses, to include the MDS Nurse, regarding Care Plans with emphasis on the responsibility of the nurse to ensure care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident□s medical, nursing, and mental/psychosocial needs to include but not limited to resident need for foley care and resident smoking status. In-service will be completed by 11/23/22. After 11/23/22, any social worker or nurse who has not completed the in-service will be in-serviced prior to next scheduled work shift. All newly hired social worker	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 656	Continued From page 42 4/1/22, and 6/1/22 revealed Resident #30 was assessed as a safe and independent smoker. Record review revealed no update to Resident #30's care plan which identified her as a safe and independent smoker. An interview was conducted the MDS Nurse who stated she was not responsible for updating Resident #30's care plan. She reported she was unsure who should have made the changes to the care plan. An interview was conducted with the Administrator on 10/12/21 at 3:24 PM who stated Resident #30 was assessed as a safe smoker in June 2022. She reported the level of supervision required by Resident #30 was based on Resident #30's physical abilities daily and this should have been reflected in Resident #30's care plan.	F 656	and nurses will be in-serviced during orientation regarding Care Plans. The Assistant Director of Nursing (ADON) will review 10 resident care plans to include resident #30 weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure resident care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident□s medical, nursing, and mental/psychosocial needs to include but not limited to resident need for foley care and resident smoking status. The MDS nurse will address all concerns identified during the audit to include updating care plan when indicated and re-education of the nurse. The Director of Nursing will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Assistant Director of Nursing (ADON) will forward the results of Care Plan Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Care Plan Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 657	Continued From page 43 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews and staff interviews, the facility failed to conduct an initial care plan meeting (Resident #69) and quarterly care plan meetings (Resident #45, #51 and #4) for 4 of 4 residents reviewed for care plan meetings. Findings included: 1. Resident #69 was admitted to the facility on	F 657	F657 Care Plan Timing and Revision On 10/21/22, a care plan meeting was conducted with resident #69 with documentation in the electronic record. On 10/20/22, a care plan meeting was conducted with resident #45 with documentation in the electronic record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 657	Continued From page 44 9/21/2022. The admission Minimum Data Set (MDS) assessment dated 9/27/2022 indicated Resident #69 was cognitively intact. A review of Resident #69's electronic medical record revealed no social services notes indicating an initial care plan meeting was held. Nursing documentation revealed no documentation of an initial care plan meeting for Resident #69. In an interview with Resident #69 on 10/11/2022, she stated she had not met as a group with the different interdisciplinary team members to discuss her plan of care since admission. The facility's social worker was not present during the survey and was unavailable for an interview. In an interview with the Admission Coordinator on 10/13/2022 at 12:01 p.m., she stated the calendar indicated a care plan meeting was scheduled for Resident #69 on 9/23/2022 at 11:30 a.m. by the social worker. She stated in the absence of the social worker, she scheduled and attended care plan meetings for new admissions only, and care plan meetings were held in the residents' rooms. In an interview with Nurse #4 on 10/13/2022 at 5:07 p.m., she stated care plan meetings should be held within seventy-two hours after admission and she was unable to locate information indicating a care plan meeting was held on 9/23/2022 for Resident #69. In an interview with the Administrator on	F 657	On 11/11/2022, a care plan meeting will be conducted with resident #51. On 11/11/2022, a care plan meeting will be conducted with resident #4. On 11/3/22, the Social Worker and Administrator initiated an audit of all current residents to include resident #69, #45, #51, #4 to ensure initial care plan meetings and quarterly care plan meetings are completed timely per facility guidelines with documentation of attendees in the electronic record. The Social Worker will address all concerns identified during the audit to include scheduling/completing care plan meeting with documentation of attendees in the electronic record and education of staff. The audit will be completed by 11/23/22. On 11/7/22, the facility consultant initiated an in-services with the Minimum Data Set Nurse (MDS) and Social Worker regarding Care Plans with emphasis on the responsibility of the Social Worker and the MDS nurse to ensure initial and quarterly care plan meetings are held per facility guidelines with documentation of attendees in the electronic record. In-service will be completed by 11/23/22. After 11/23/22, any social worker or MDS nurse who has not completed the in-service will be in-serviced prior to next scheduled work shift. All newly hired social worker and MDS nurse will be in-serviced during orientation regarding Care Plans. The Assistant Director of Nursing (ADON)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 657	Continued From page 45 10/14/2022 at 5:52 p.m., she stated care plan meetings included interdisciplinary team members and were expected to be held in conjunction with the admission MDS assessment and documented in the resident's medical record. 2. Resident #45 was admitted to the facility on 2/16/2021. A review of Resident #45's medical record revealed an interdisciplinary care conference was conducted on 5/14/2021. There were no further notes indicating care plan meetings were conducted. The quarterly Minimum Data Set (MDS) assessment dated 9/8/2022 indicated Resident #45 was cognitively intact. In an interview with Resident #45 on 10/10/2022 at 3:03 p.m., he stated he had not met with different interdisciplinary team members to discuss his plan of care and had only spoken with the social worker about discharge from the facility. The facility's social worker was not present during the survey and was unavailable for an interview. In an interview with the Admission Coordinator on 10/13/022 at 11:37 a.m., she stated the social worker scheduled the quarterly and annual care plan meetings. She stated she only scheduled and attended initial care plan meetings in the absence of the social worker. In an interview with Nurse #4 on 10/13/2022 at 5:07p.m., she stated care plan meeting should be held annually and quarterly in conjunction with	F 657	will review 15 resident care plans to include resident #69, #51, #4, #45 weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure initial care plan meetings and quarterly care plan meetings are completed timely per facility guidelines with documentation of attendees in the electronic record. all concerns identified during the audit to include scheduling/completing care plan meeting with documentation of attendees in the electronic record and education of staff. The Director of Nursing will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of Care Plan Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Care Plan Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 657	Continued From page 46	F 657		

MDS assessments. She stated she was unable to locate information indicating a quarterly care plan meeting was held for Resident #45 in September 2022.

In an interview with the Administrator on 10/13/2022 at 5:58 p.m., she stated the social worker had been meeting with Resident #45, and interdisciplinary care plan meetings were to be conducted in conjunction with quarterly and annual MDS assessments.

3. Resident #51 was admitted to the facility on 2/2/22 with diagnoses including hypertension and diabetes.

The quarterly Minimum Data Set (MDS) dated 9/14/22 for Resident #51 revealed he was cognitively intact.

An interview was conducted with Resident #51 on 10/10/22 at 10:25 and he stated he could not recall attending a care plan meeting.

A review of Resident #51's record was completed and revealed no evidence of care plan meetings being held.

An interview was conducted with the MDS Nurse on 10/13/22 at 12:00 PM. She stated she did not attend care plan meetings. She stated she was unable to verify if a care plan meeting had been held for Resident #51.

The Admission Coordinator was interviewed on 10/13/22 at 1:30 PM. She reported the social worker scheduled the quarterly and annual care plan meetings. She stated she only attended initial care plan meetings and was unable to verify if care plan meetings had been held for Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 657	Continued From page 47	F 657		

#51.

The facility's social worker was not present during the survey and was unavailable for an interview.

An interview was conducted with Assistant Director of Nursing on 10/14/22 at 5:00 PM. She stated she was unable to locate documentation of care plan meetings held for Resident #51.

In an interview with the Administrator on 10/14/2022 at 5:52 PM, she stated care plan meetings were expected to be held in conjunction with annual and quarterly MDS assessments and documented in the resident's medical records.

4. Resident #4 was admitted to the facility on 6/17/21 with diagnoses including diabetes and depression.

The quarterly Minimum Data Set dated 6/13/22 revealed Resident #4 was cognitively intact.

An interview was conducted with Resident #4 on 10/10/22 at 10:54 and he stated he had never been to a care plan meeting.

A review of Resident #4's electronic record revealed a care plan meeting took place on 6/23/21. There was no evidence in Resident #4's electronic record if other care plan meetings took place.

An interview was conducted with the MDS Nurse on 10/13/22 at 12:00 PM. She stated she did not attend care plan meetings. She stated she was unable to verify if a care plan meeting had been held for Resident #4.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 657	Continued From page 48 The Admission Coordinator was interviewed on 10/13/22 at 1:30 PM and she stated she attends the first care plan meeting after admission. She reported the social worker scheduled the quarterly and annual care plan meetings. She stated she does not attend the quarterly meetings and was unable to verify if a care plan meeting took place for Resident #4. The facility's Social Worker was not present during the survey and unavailable for an interview. An interview was conducted with Assistant Director of Nursing on 10/14/22 at 5:00 PM and she stated she was unable to locate documentation of a care plan meeting taking place for Resident #4. In an interview with the Administrator on 10/14/2022 at 5:52 p.m., she stated care plan meetings included interdisciplinary team members and were expected to be held in conjunction with the annual and quarterly MDS assessment and documented in the resident's medical record.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to	F 661		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 661	Continued From page 49 include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a recapitulation of stay at the facility for 1 of 1 resident reviewed for discharges (Resident #72). Findings included: Resident #72 was admitted to the facility on 8/17/22 with diagnoses that included diabetes mellitus and hypertension. Review of Resident #72's's discharge Minimum Data Set (MDS) assessment dated 9/08/22 revealed she was cognitively intact. Review of Resident #72's medical record revealed she was discharged Against Medical Advice (AMA) on 09/08/22.	F 661	F661 Discharge Summary Resident #72 no longer resides in the facility as of 9/2/22. On 11/7/22, the facility consultant initiated an audit of all discharges for the past 30 days. This audit is to ensure a recapitulation of resident stay was completed to include but not limited to diagnoses, course of illness/treatment/therapy, pertinent lab/radiology, consultation results, medications and post discharge plan of care. The Director of Nursing assigned hall nurse and physician will address all concerns identified during the audit to include completion of recapitulation when	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 661	Continued From page 50 Further review of the record revealed there was no evidence the facility completed a recapitulation of stay for Resident #72. Review of a nursing note dated 9/8/22 specified Resident #72 left AMA to return home. Interview with the MDS nurse on 10/13/22 at 2:07 PM revealed a discharge summary and recapitulation of stay was not completed. The MDS nurse further stated she was not aware a discharge summary and recapitulation of stay needed to be completed for Resident #72. Interview with the Administrator on 10/13/22 at 3:44 pm revealed it was her understanding once a resident signs out as AMA, the facility is no longer obligated or responsible to fax documents to her Primary Care Physician (PCP) or reach out to the resident concerning discharge instructions or recapitulation of stay. The Administrator stated a discharge summary was not completed for Resident #72.	F 661	indicated. Audit will be completed by 11/23/22. On 11/7/22, the Assistant Director and Director of Nursing initiated an in-service with all nurses, social worker, Therapy Director, Dietary Manager and Physician regarding Discharge Summary with emphasis on completing a recapitulation of resident stay. In-service will be completed by 11/23/22. After 11/23/22, any nurse, Social Workers, Therapy Director, Dietary Manager and Physician who has not received the in-service will receive in-service upon next scheduled shift. All newly hired nurses, social worker, Therapy Director, Dietary Manager and physician will be in-serviced during orientation regarding Discharge Summary. The IDT team to include Director of Nursing, Social Worker, Dietary Manager and MDS nurse will review 10% of all discharges weekly x4 weeks then monthly x 1 month utilizing the Discharge Summary Audit Tool. This audit is to ensure a recapitulation of stay is completed to include but not limited to diagnoses, course of illness/ treatment/ therapy, pertinent lab/radiology, consultation results, medications and post discharge plan of care. The Director of Nursing, Nurse Supervisor, and Social Worker will address all concerns identified during the audit. The Administrator will review and initial the Discharge Summary Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 661	Continued From page 51	F 661	addressed. The Administrator will forward the results of the Discharge Summary Audit Tool to the Executive QAPI Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Discharge Summary Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and observations the facility failed to provide nail care for a dependent resident for 1 of 26 residents reviewed for activities of daily living (Resident #25). Findings included: Resident #25 was admitted to the facility on 6/2/22 with diagnoses including hypertension and diabetes. The quarterly Minimum Data Set (MDS) dated 8/25/22 revealed Resident #25 had moderate cognitive impairment. He required extensive assistance with bed mobility and transfers occurred once or twice. Supervision was	F 677	F677 ADL Care Provided for Dependent Residents On 11/2/22, the hall nurse trimmed and provided nail care to resident #25. On 11/3/22, the Activity Director initiated an audit of nail care for all residents to include resident #25. This audit is to ensure staff provided nail care to include cleaning and trimming per resident preference to maintain good grooming and personal hygiene. The Activity Director, nursing assistant or assigned nurse will address all concerns identified during the audit to include cleaning and/or trimming nails per resident preference	11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 677	Continued From page 52 required for eating and total assistance was needed for toilet use. The MDS indicated Resident #25 did not have behaviors of rejecting care. Resident #25's care plans updated on 8/31/22 revealed a care plan for activities of daily living/personal care. The goal included activities of daily living/personal care would be completed with staff support as appropriate to maintain or achieve highest practical level of functioning through the next review. Resident #25 was also care planned for problematic manner in which resident acts characterized by inappropriate behavior; resistive to treatment/care (incontinence care, bathing, dressing) related to personal preference. An observation and interview were conducted on 10/10/22 at 12:43 PM. Resident #25 stated his fingernails were past the fingertip and needed cutting. He stated staff cut them occasionally. All fingernails on both hands of Resident #25 appeared to be approximately one quarter inch above the fingertips, jagged, and with blackish brown matter under the nails. On 10/11/22 at 10:25 AM an observation revealed fingernails on both hands of Resident #25 appeared to be approximately one quarter inch above the fingertips, jagged, and with blackish brown matter under the nails. An interview was conducted with NA #8 on 10/11/22 at 2:45 PM, and she stated she was not allowed to cut the fingernails of a diabetic resident. She stated Resident #25 refuses a lot. Nurse #21 was interview on 10/11/22 at 2:54 PM,	F 677	and education of staff. Audit will be completed by 11/23/22. On 11/2/22, the Social Worker initiated resident questionnaires regarding Resident Preferences with emphasis on (1) Are you able to choose a bath or shower to include time of bath/shower? (2) Do you have a preference on nail care/Length? (3) Do you have a preference on removal of facial hair? (4) Do you have a preference on times to get out of or going back to bed? The Social Worker and hall nurse will address all preferences identified during the questionnaires to include updating care plan when indicated and education of staff. The questionnaires will be completed by 11/23/22 On 11/7/22, the Assistant Director of Nursing and Director of Nursing initiated an in-service with all nurses and nursing assistants regarding (1) Activities of Daily Living (ADL) with emphasis on staff responsibility to provide assistance to any resident who is unable to carry out activities of daily living to include but not limited to nail care to maintain good nutrition, grooming and personal/oral hygiene and (2) Resident Preference with emphasis on resident right to make choices of activities of daily living. In-service will be completed by 11/23/22. After 11/23/22 any nurse or nursing assistant who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses and nursing assistants	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 677	Continued From page 53 and she stated she was caring for Resident #25. She stated she was not allowed to cut the fingernails of a resident with diabetes. She stated she noticed his nails were long yesterday and was going to clean them, but she got too busy. An interview was conducted with Nurse #1 on 10/11/22 at 3:06 PM and he stated he could cut the fingernails of a diabetic resident. He stated he was not always aware of dirty long nails but if he becomes aware he would address them. A nursing note in Resident #25's chart by Nurse #21 on 10/11/22 at 7:23 PM stated nails were cleaned this afternoon. Resident was resisting care but with the help of a nursing assistant nails were able to be cleaned. An interview was conducted with the Corporate Nurse Consultant on 10/13/22 at 12:13 PM, and she stated nail care was provided to residents on shower days and as needed. She stated nursing assistants are allowed to trim fingernails of diabetic residents.	F 677	will be in-serviced during orientation regarding Activities of Daily Living and Resident Preference. The Activity Director will review nail care for all residents to include resident #25 weekly x 4 weeks then monthly x 1 month utilizing a resident census sheet. This audit is to ensure staff provided nail care to include cleaning and trimming per resident preference to maintain good grooming and personal hygiene. The Activity Director, nursing assistant and assign hall nurse will address all concerns identified during the audit to include cleaning and/or trimming nails per resident preference and/or re-training of staff. The Director of Nursing will review the Nail Care Audit/census sheet weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will present the findings of the Nail Care Audit/census sheet to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Nail Care Audit/census sheet to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 54 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow physician's orders by not administering lorazepam three times as ordered for anxiety and failed to treat a resident for nausea for 2 of 20 residents reviewed for quality of care (Resident #27 and Resident #172). 1. Resident #27 was admitted to the facility on 5/25/21 with diagnoses that included depression. Resident #27's Minimum Data Set assessment dated 8/26/22 revealed Resident #27 was assessed as cognitively intact. Review of Resident #27's medical record revealed a physician's order dated 9/9/22 for lorazepam (antianxiety agent) .5 milligrams three times a day at 9:00 AM, 1:00 PM and 9:00 PM for anxiety. Review of Resident #27's Medication Administration Record (MAR) revealed at 9:00 PM on 10/10/22 the lorazepam was documented as not given and not available and initialed by Nurse #8. The 9:00 AM and 1:00 PM dose of lorazepam was documented by Medication Aide #1 as not given and not available. There were no other missing doses of lorazepam documented on the MAR.	F 684	F684 Quality of Care On 10/11/22, the assigned nurse notified the physician of missed doses of lorazepam for resident #27 and supply not available. A new prescription was obtained and faxed to the pharmacy. The facility obtained the prescribed medication of Lorazepam for resident #27 on 10/11/22. The medication was administered at 9 pm and continues three times a day per physician orders. The resident was assessed by the nurse with no negative outcomes identified. On 10/10/22, resident #172 was provided anti-nausea medication and reported it as effective. On 11/1/22, the facility pharmacy consultant initiated an audit of all electronic medication administration record (eMAR) from 10/1/22-10/31/22. This audit was to ensure medications were administered per physician orders with documentation on the electronic eMAR. The facility consultant will address all concerns identified during the audit to include assessment of the resident, providing medication per physician order	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 55 An interview was conducted with Resident #27 on 10/11/22 at 10:09 AM she stated she was very concerned that she did not receive one of her medications on 10/10/22 and 10/11/22. She reported she was told they were out of her lorazepam and was scheduled for another dose on 10/11/22 in the afternoon. She reported she was feeling very "nervous" without her medication. An interview was conducted with Nurse #8 on 10/13/22 at 2:45 PM. He stated he documented he was unable to give Resident #27 her dose of lorazepam on 10/10/22 on 9:00 PM. Nurse #8 stated he reported this information the next day to the ongoing shift. During an interview with Nurse #7 on 10/11/22 at 10:34 AM he reported the facility was awaiting a pharmacy delivery of lorazepam. He reported he had spoken with the resident. Nurse #7 stated he made the physician aware of the missed doses when the provider came in to write a required prescription for the lorazepam (a controlled drug). An interview was conducted with Resident #27 on 10/11/22 at 2:00 PM and she stated she did not receive her lorazepam in the morning or afternoon of 10/11/22. She reported she continued to have some feelings of anxiety without her medication. During an interview with Medication Aide #1 on 10/11/22 at 2:05 PM she reported Resident #27's the lorazepam was unavailable that day at 9:00 AM and 1:00 PM, and she reported it to Nurse #7 on the morning of 10/11/22 as she was trained.	F 684	and/or notification of the physician for further recommendation when indicated. The audit will be completed by 11/23/22. On 11/2/22, the facility consultant completed an audit of medications not administered documented as not available for the past 30 days. This audit is to identify any medications not currently available to administer to ensure medications are obtained from pharmacy/back up pharmacy and/or the physician notified that medications are not available for further recommendations. There were no additional concerns identified. On 11/7/22, the hall nurses completed an audit of all medication carts to current resident MARs to ensure medications were available for administration per physician orders. The hall nurses will address all concerns identified during the audit to include notification of pharmacy to obtain medications when indicated and/or notification of the physician if medication cannot be obtained for further recommendations. The audit will be completed by 11/23/22 On 11/7/22, the Assistant Director of Nursing and the Director of Nursing initiated an in-service with all nurses regarding Following Physician□s Orders with emphasis on signing MAR immediately after administering medication, process for obtaining medication when not available and/or notification of physician when medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 56 An interview was conducted with Nurse #7 on 10/11/22 at 3:15 PM. Nurse #7 stated he was made aware Resident #27 did not have any lorazepam available when he came on shift. He reported the physician wrote a prescription for lorazepam today and it should be arriving on the evening on 10/11/22. Nurse #7 stated there should have been lorazepam in medication storage, but their storage was out of the medication as well. Nurse #7 explained he contacted the doctor, and a prescription was written. During this interview Nurse #7 contacted the pharmacy to ensure they had received the faxed prescription for the lorazepam. During an interview with Resident #27 on 10/12/22 she stated she received her bedtime dose of her lorazepam on 10/11/22. During an interview with Director of Nursing (DON) #1 on 10/11/22 at 3:30 PM she reported the nurses should have ordered lorazepam prior to Resident #27 running out of it. She reported she was unsure who should have ensured there was an ample supply in medication storage. DON #1 reported when the medication was "low" the nurses should have written a note in the physician's communication book that a new prescription was needed. DON #1 stated an emergency supply should have been in the storage room. DON #1 stated the hall nurse was responsible for getting the physician to write an order if needed. She reported Nurse #8 followed procedure for advising the oncoming nurse aware of the need for a prescription. DON #1 stated their pharmacy delivered medications to the facility each evening, so another emergency pharmacy is not necessary.	F 684	not available for further recommendations. In-service will be completed by 11/23/22. After 11/23/22 any nurse or medication aides who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses and medication aides will be in-serviced during orientation regarding Following Physician Orders. The IDT team to include Minimum Data Set Nurse, Assistant Director of Nursing, and Director of Nursing will review Not Administered Report 5 times a week x 4 weeks then monthly x 1 month. This audit is to ensure medications are available to administer per physician order and that the nurse documented on MAR following administration. The Minimum Data Set Nurse, Assistant Director of Nursing, and Director of Nursing will address all concerns identified during the audit to include obtaining medications when indicated, notification of the physician for any missed doses and re-training of staff. The Administrator will review the Not Administered Report 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will present the findings of the Not Administered Report to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Not Administered Report to determine trends and/or issues that may	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 57	F 684		

An interview was conducted with the facility Administrator on 10/14/22 at 3:24 PM who stated nursing staff should have ensured Resident #27 received all doses of her prescribed medication.
2. Resident #172 was admitted to the facility on 9/30/2022, and diagnoses included gastroenteritis, an inflammation of stomach and intestines.

Physician orders dated 9/30/2022 revealed an order for Ondansetron 4 milligrams (mg) orally every eight hours as needed for nausea and vomiting.

The care plan dated 10/5/2022 included a focus for gastroenteritis, and interventions included observing for nausea and administering medications as ordered by the physician.

The admission Minimum Data Set (MDS) assessment dated 10/6/2022 indicated Resident #172 was cognitively intact.

A review of the October 2022 Medication Administration Record on 10/11/2022 revealed Resident #172's last dose of Ondansetron 4mg documented on the MAR prior to 10/10/2022 was on 10/9/2022 at 7:46 a.m. Nurse #1 signed administering Resident #172 her 8:00 a.m. and 9:00 a.m. medications on 10/10/2022.

On 10/10/2022 at 11:15 a.m. in an interview with Resident #172, she stated she was nauseated and she had rung the call bell device all night and all morning, and no one had come to her room to tell them she needed some medication for nausea. She stated the wash basin lined with clean paper towels observed at the foot of the bed was in case she vomited. She stated she had need further interventions put into place and to determine the need for further frequency of monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 58	F 684		

not vomited but was unable to eat her breakfast due to the nausea.

On 10/10/2022 at 11:21 a.m., a continuous observation started when Resident #172 was observed activating the call bell device. On 10/10/2022 at 11:31 a.m., the call light above Resident #172's door was observed lit, and Nurse #1 and Nurse Aide #5 were observed providing care to other residents across the hallway. Nurse #1 was observed on 10/10/2022 at 11:33 a.m. exiting resident's room across the hallway to the medication cart positioned on the adjacent hallway. On 10/10/2022 at 11:37 a.m., the audible call bell device system was observed at the centralized nurse's station, and the screen of the call bell system indicated Resident #172's call bell device had been activated for eighteen minutes. There were no facility staff members observed at the centralized nurse's station. On 10/10/2022 at 11:43 a.m., Admission Coordinator was observed entering Resident #172's room. The Admission Coordinator was observed telling Resident #172, "I'll go get your nurse" and did not turn off the call bell device. On 10/10/2022 at 11:47 a.m. Nurse #4 was observed entering Resident #172 room and exiting with call bell device still activated. An audible overhead page was heard for Nurse #1 to the nurse's station. On 10/10/2022 at 11:54 a.m. NA #5 was observed entering Resident #172's room and turning off the call bell device.

On 10/10/2022 at 12:35 p.m. in an interview with Resident #172, she stated she received her medication for nausea around 12:10 p.m. and was feeling better and able to rest.

A review of the October 2022 Medication Administration Record on 10/11/2022 revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 59 Resident #172 received a dose of Ondansetron 4mg, a nausea medication, on 10/10/2022 at 10:14 p.m. with relief. On 10/11/2022 at 1:55 p.m. in an interview with Nurse Aide (NA) #5, she stated Resident #172 complained of nausea when the breakfast meal tray was delivered around 8:00 a.m. to her room, and she informed Resident #172's nurse. On 10/11/2022 at 2:40 p.m. in an interview with Nurse #1, he stated his assignment on 10/10/2022 included Resident #172 and she was administered Ondansetron 4mg for complaints of nausea upon learning the resident was complaining of nausea sometimes after 12:00 p.m. He stated was trying to learn the new residents on the 100-hall and responded accordingly when told of resident's needs. He stated he was not sure if NA #5 informed him on 10/10/2022 that Resident #172 was nauseated earlier that morning and he did not know Resident #172 was complaining of nausea because Resident #172's call light outside the room was not visual from the main 100-hall way.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 686	Continued From page 60 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to perform wound care as physician ordered to a pressure ulcer for 1 of 2 residents reviewed with pressure ulcers. (Resident #69) Findings included: Resident #69 was admitted to the facility on 9/21/2022 with diagnoses that included osteomyelitis of the sacral and coccyx vertebrae. The admission Minimum Data Set (MDS) assessment dated 9/27/2022 indicated Resident #69 was cognitively intact, required assistance with activities of daily living and was receiving wound care for a stage 4 pressure ulceration that was present on admission. The care plan dated 9/27/2022 included a focus for ulceration or interference with structural integrity of layers of skin caused by pressure related to immobility, and interventions included treatment as ordered by physician. Physician orders dated 9/30/2022 revealed an order to apply Santyl ointment, a medicine that removes dead tissue from wounds so they can start to heal, 250 units/gram topically to the edges of the wound on the right buttocks every day shift for wound care and to clean the wound on the right buttock with wound cleanser, dry the wound and pack wound loosely with Dakins 0.125%	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcer On 10/17/22, resident #69 sacral wound was assessed following readmission to the facility and treatment initiated. The physician notified of wound status On 11/7/22, the hall nurses initiated a 100% skin check on all residents. This audit is to identify any resident with new skin concerns or wounds to ensure all concerns have been properly assessed, treatment initiated as indicated, MD/RR notified, documentation completed in the Wound Ulcer Flowsheet or Non-Ulcer Flowsheet, incident report completed for any newly identified wounds and care plan updated. All areas of concern will be immediately addressed by the hall nurses, assistant director of nursing and treatment nurse to include assessment of resident, completion of incident report, notification of MD/RR, initiating treatment per MD orders, documentation in Wound Ulcer Flowsheet or Non-Ulcer Flowsheet and updating care plan. Audit will be completed by 11/23/22. On 10/18/22, the facility consultant initiated an audit of all treatment administration records (TAR) for all residents from 10/1/22 to 10/17/22. This	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 686	Continued From page 61 solution, used to prevent and treat sim and tissues infections that could result from pressure ulcers, wet gauze, cover with ABD pad, a highly absorbent dressing that provides padding and protection for large wound, and secure with tape. A review of the pressure ulcer flow sheet dated 9/30/2022 revealed Resident #69 had a sacrum wound measuring 9x5x4 centimeters with full thickness of tissue loss and reddish pink colored tissue. Slough was present on the surrounding edges of the wound and the outer edges were a pale gray color. The wound was draining serosanguinous material with a mild purulent drainage also present. A review of the October 2022 Treatment Administration Record (TAR) revealed Resident #69's wound treatment was not documented as completed on the weekend of 10/1/2022 and 10/2/2022. In an interview with Nurse #11 on 10/14/2022 at 1:35 p.m., she stated on weekends there was too many tasks to performed for the nursing supervisor to be responsible for wound care, and on 10/1/2022, she was reassigned to the 100-hall medication cart. She stated she could not recall changing Resident #69's wound dressing on 10/1/2022 and if wound care was not documented as provided on the TAR, she did not perform the wound care. In an interview with Nurse #12 on 10/14/2022 at 4:26 p.m., she stated she worked different areas in the facility and could not recall changing Resident #69's sacral wound on 10/2/2022. She stated she passed resident's their medications and other nurses performed the wound	F 686	audit is to ensure treatments were completed per physician order with documentation on the TAR. The facility consultant and hall nurse will address all concerns identified during the audit to include assessment of the resident, initiating treatment per physician order, notification of the physician of treatment omission/wound status for further recommendations and education of staff. The audit will be completed by 11/23/22. On 11/7/22, the Assistant Director of Nursing and Director of Nursing initiated an in-service with all nurses regarding (1) Wound Process with emphasis on assessing, initiating treatment and notification of the physician/resident representative for all newly identified skin concerns or changes in wound status (2) Treatments/TAR documentation with emphasis on nurse responsibility to complete treatments in the absence of treatment nurse, signing TAR immediately after completing treatment and notification of the physician if treatment cannot be completed for further instructions. The in-service will be completed by 11/23/22. After 11/23/22 any nurse who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Wound Process and TAR Documentation/Treatments The IDT team to include Minimum Data Set Nurse, Assistant Director of Nursing and Director of Nursing will review Not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 686	Continued From page 62 treatments. She stated she did not know why the wound care was not provided. On 10/11/2022 at 11:10 a.m. in an interview with Resident #69, she stated nursing staff were not changing the pressure ulcer dressing on weekends. There was no observation of Resident #69's sacral wound due to Resident #69's admission to the hospital on 10/12/2022. In an interview with the Nurse #7 on 10/14/2022 at 8:50 p.m., he stated as the wound nurse, he performed daily wound care to Resident #69 Monday through Friday, and nursing supervisors performed wound care on the weekends. He stated when nursing supervisors were reassigned to a medication cart on the weekends, nurses on the medication carts were responsible for performing wound care per physician orders. Nurse #7 stated based on clean, granulated tissue and decreased sloughy wound edges, there was visual improvement in Resident #69's sacral wound since admission. In an interview with the Administrator on 10/14/2022 at 6:07 p.m., she stated wound care dressing were to be changed per physician's orders.	F 686	Administered Report 5 times a week x 4 weeks then monthly x 1 month. This audit is to ensure treatments were completed per physician order and that the nurse documented on TAR following treatment. The Minimum Data Set Nurse, Assistant Director of Nursing and Director of Nursing will address all concerns identified during the audit to include completing treatment per physician order, assessment of the resident, notification of the physician for any missed treatments and re-training of staff. The DON will review the Not Administered Report 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will present the findings of the Not Administered Report to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Not Administered Report to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 63 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interviews and staff interviews, the facility failed to implement the facility's smoking policy for conducting smoking assessments on residents (Resident 350, #30, #65, #24, #4) observed smoking in the designated smoking area, to supervise a resident who was assessed to require supervision while smoking (Resident #50) and to secure smoking materials that included cigarettes and a lighter (Resident #50) for 5 of 5 residents reviewed for smoking. Findings included: The facility's smoking policy dated 3/27/2019 stated assessment of resident's ability to smoke in a safe manner would occur prior to smoking in designated outside area. All resident smoking materials were maintained in a secured area and were accessible only through the assistance of the facility's staff. A licensed nurse, upon admission, re-admission or significant change, would assess each resident who desires to smoked, utilizing the smoking evaluation. Residents determined to be unsafe smokers will be assessed at least quarterly and safe smokers at least monthly, utilizing the smoking evaluation by a licensed nurse. 1. Resident #50 was admitted to the facility on 5/12/2021. The smoking assessment dated 4/1/2022 indicated Resident #50 was an unsafe smoker	F 689	F689 Free of Accident Hazards On 10/13/22 resident #50 was assessed for injury following report that resident dropped a cigarette onto pants. No injury identified. Resident denied injury. On 10/10/22, Resident #50 was assessed for smoking safety and was identified as safe/independent smoker. The care plan accurately reflects resident smoking status. On 10/10/22, Resident #30 was assessed for smoking safety and was identified as requiring supervision to when smoking. The care plan accurately reflects resident smoking status. On 10/10/22, Resident #4 was assessed for smoking safety and was identified as safe/independent smoker. The care plan accurately reflects resident smoking status. On 10/10/22, Resident #24 was assessed for smoking safety and was identified as safe/independent smoker. The care plan accurately reflects resident smoking status. On 10/10/22, the Director of Nursing initiated smoking assessment on all residents who smoke or desire to smoke.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 64 and required direct supervision while smoking. The care plan dated 4/25/2022 revealed Resident #50 used tobacco products and was an independent, safe smoker. Interventions included upon return from smoking area to ensure smoking materials were placed in secured storage area. The annual Minimum Data Set (MDS) assessment dated 5/20/2022 indicated Resident #50 was cognitively intact, required assistance with activities of daily living and had impairments to one side of the body. The MDS indicated Resident #50 did not use tobacco products. Resident #50 stated in an interview on 10/10/2022 at 2:36 p.m. his cigarettes were kept in a box at the front desk, and he smoked in the facility's designated area without staff accompanying him. During a continuous observation on 10/10/2022 beginning at 3:26 p.m., Resident #50 was observed entering the facility's designated smoking area. Resident #50 was observed with a pack of cigarettes and lighter in his possession. Using his left hand, he was observed lighting the cigarette, holding the cigarette and transferring the cigarette toward his mouth without difficulty. Resident #50 was observed with his head down and eyes closed momentarily at intervals during the continuous observation. On 10/10/2022 at 3:35 p.m., Resident #50 was observed dropping his cigarette on the left side of his sweatpants near the pocket. Resident #50 immediately picked up the cigarette, inhaled the cigarette and extinguished the cigarette into a metal ash tray before exiting the facility's designated smoking	F 689	This assessment is to identify resident ability to smoke safe/independently or who require supervision. The care plan will be updated for all resident□s current smoke status following assessment. Assessments will be completed by 11/23/22. On 11/7/22, the Social Worker initiated an audit of all residents who smoke for smoke paraphernalia. This audit is to identify any resident with smoke material that was not stored per facility protocol. The Social Worker will address all concerns identified during the audit to include removing smoke paraphernalia from resident care areas, storing smoke paraphernalia per facility protocol and education of the resident. Audit will be completed by 11/23/22 On 10/10/22, the Administrator reviewed the smoke policy to include (1) Storage of Smoking Materials (2) Designated Outside Smoking Areas/times (3) Policy Violations with all residents identified as smokes or desires to smoke. The in-service was completed on 10/10/22. On 11/7/22, the Assistant Director of Nursing and Director of Nursing initiated an in-service for all facility staff to include agency in regards to Monitoring Smoking Paraphernalia to include (1) Designated smoke times for supervised smokers (2) All supervised smokers must be monitored during smoke times to ensure they are safe and are not obtaining additional smoke paraphernalia from staff,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 65 area. A phone interview was conducted with Nurse #6 on 10/10/2022 at 4:45 p.m. She stated smoking assessments were conducted quarterly and had not been conducted on Resident #50 due to nursing supervisors had been reassigned to medication carts. She stated Resident #50 was able to light, hold and extinguish the cigarette and did not require supervision. When asked why she marked Resident #50 as an unsafe smoker and required direct supervision while smoking on his smoking assessment dated 4/1/2022, she stated because after smoking Resident #50 stayed out in the facility's designated smoking area for long periods of time and would fall asleep while sitting up in his wheelchair, and nursing staff needed to assess Resident #50 and assist back into the facility as needed. She stated she had never observed Resident #50 falling asleep while smoking and his plan of care did not reflect assessing the resident after smoking because she had not shared the information with management staff. In an interview on 10/10/2022 at 5:15 p.m. with Resident #50, he stated he has a habit of closing his eyes when smoking and stated he did not fall asleep while smoking. An oblong brown edged circle hole measuring one centimeter by one centimeter was observed to the pocket area on the left side of Resident #50's navy blue sweatpants. Resident #50 stated he just lost his grip on the cigarette when it fell out of his hand. When Resident #50 was asked if he still had possession of his cigarettes, he was observed pulling out a pack of cigarettes with a lighter from the left backside of his wheelchair. He stated he kept possession of his smoking materials until	F 689	residents or visitors. (3) Staff should ensure all smoke paraphernalia is returned immediately upon return to the facility (4) Staff should report to the assigned nurse, nurse supervisor, DON or Administrator immediately for any concerns related to smoke safety or any resident who has smoke paraphernalia that is not secured properly. In-service will be completed by 11/23/22. After 11/23/22, any staff who has not worked or completed the in-service will complete prior to next scheduled work shift. All newly hired staff will be in-serviced during orientation by the Staff Facilitator regarding Monitoring Smoking Paraphernalia On 11/7/22, the Assistant Director of Nursing and Director of Nursing initiated an in-service with all nurses regarding Smoking Assessments with emphasis on completing smoking assessments per facility protocol and updating care plan for all changes in smoke status. In-service will be completed by 11/23/22. After 11/23/22, any nurse who has not worked or completed the in-service will complete prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation by the Staff Facilitator regarding Smoking Assessments. The Medical Records Director will review smoking assessments for all identified residents who smoke or desire to smoke weekly x 4 weeks then monthly x 1 month utilizing the Smoking Audit Tool. This audit is to ensure the resident is assessed for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 66 bedtime, and at bedtime, he returned his smoking materials to the nursing station. In an interview with Certified Medication Aide (CMA) #1 on 10/10/2022 at 5:30 p.m., she stated Resident #50 did not require supervision for smoking and smoking materials were stored at the nurse's station. She explained the nursing supervisor gave residents their smoking materials and unlocked the door for residents to enter and exit the designated smoking area and gathered the smoking materials back from the resident when entering the facility. The staff member who assisted Resident #50 exiting the designated smoking area during the observation on 10/10/2022 was unable to be identified and interviewed. In an interview with the Interim Director of Nursing (DON) on 10/10/2022 at 5:31 p.m., she stated there was not a nursing supervisor scheduled to monitor the nursing station area for 10/10/2022, and when there was no nursing supervisor scheduled, other staff members assisted the residents with gathering smoking materials and unlocking the keypad door to enter and exit the designated smoking area. She stated none of the smokers in the facility required staff supervision when smoking, and staff members who assisted the residents exiting from the designated smoking area were to ask residents for their smoking materials and return the items to the nursing station. When the DON was informed Resident #50 had cigarettes and a lighter in his possession, she stated he should not have his smoking materials in his possession. She further stated smoking assessments were conducted on admission and that she needed to	F 689	smoking safety with education on smoking policy to include storage of smoke paraphernalia and care plan updated to accurately reflect smoke status. The Medical Records Director and Assistant Director of Nursing will address all concerns identified during the audit to include assessment and education of the resident and updating care plan when indicated. The Director of Nursing will review the Smoking Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will present the findings of the Smoking Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Smoking Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 67	F 689		

review the policy to determine when smoking re-assessments were conducted.

In an interview with Nurse Aide (NA) #3 on 10/11/2022 at 8:55 a.m., she stated Resident #50 was a supervised smoker and nurse aides or staff at the nursing station accompanied Resident #50 when he smoked. She stated Resident #50 stayed awake late into the night, and she had observed him closing his eyes when out in the designated smoking area. She stated she had never observed Resident #50 dropping his cigarette when smoking. She also stated the staff member accompanying Resident #50 exiting the designated smoking area was responsible for gathering his smoking materials and returning to the box at the nursing station.

In an interview with NA #4 on 10/11/2022 at 9:06 a.m. he stated Resident #50 did not require supervision when smoking. He stated Resident #50 could hold and light his own cigarette. He stated the staff member who assisted Resident #50 exiting the designated smoking area was to gather smoking materials from him and return the items to the box at the nursing station. During hot summer days, he stated he had observed Resident #50 sitting outside in the designated smoking area not smoking with his eyes closed. He further stated he had not observed burnt areas to Resident #50's clothing or Resident #50 dropping his cigarette when smoking.

In an interview with Nurse #7 on 10/11/2022 at 9:00 a.m., he stated smoking assessments were conducted on all residents who smoked to determine whether supervision or no supervision was required when smoking. He stated he did not know Resident 50's supervision status and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 68	F 689		

would need to check Resident #50's electronic medical record He stated he rarely observed Resident #50 in the designated smoking area and had not observed Resident #50 falling asleep or dropping a cigarette while smoking. He stated smoking materials were gathered and returned to the box at the nursing station by the staff member assisting Resident #50 to exit the designated smoking area.

A follow-up interview was conducted with the Interim DON on 10/11/2022 at 3:06 p.m. with Regional Nurse Consultant #1 present. The DON stated the smoking assessment dated 4/1/2022 indicating Resident #50 required supervision was not an accurate assessment, and Resident #50 was re-assessed for smoking on 10/10/2022 as a safe independent smoker. The Regional Nurse Consultant #1 stated smoking assessments were to be conducted quarterly for supervised smokers and monthly for safe, independent smokers, and smoking assessments populated automatically on the electronic medical record based on the initial smoking assessment. The DON stated nursing supervisors had been completing the smoking assessments when not assigned to a medication cart, and all nursing staff were responsible for conducting smoking assessments.

In an interview with the Administrator on 10/14/2022 at 5:35 p.m., she stated smoking assessments were to be completed per the facility policy and needed to reflect an accurate assessment of Resident #50. She stated she had never observed any burnt areas to Resident #50's clothing. Based on how the questions were answered on the smoking assessment dated 4/1/2022, she stated Resident #50 was a safe, independent smoker and should not had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 69	F 689		

marked as an unsafe smoker requiring direct supervision.
2. Resident #30 was admitted to the facility on 4/21/21.

A smoking assessment dated 06/01/22 revealed Resident #30 was assessed as a safe and independent smoker.

Resident #30's most recent Minimum Data Set (MDS) assessment dated 8/29/22 revealed she was cognitively intact.

Resident #30's record review revealed monthly smoking assessments were not completed during the months of July, August, and September 2022.

Resident #30's active care plan (initiated on 08/24/21) revealed she was care planned as a smoker who needed staff supervision.

An interview was conducted with Resident #30 on 10/11/22 at 9:30 AM. She stated she smoked since she was admitted to the facility. Resident #30 stated she smoked without supervision up until approximately two weeks ago. She reported the Administrator spoke with her on 10/10/22 regarding her being a smoker who required staff supervision. She reported nursing staff kept her cigarettes and her smoking materials.

An interview was conducted with the Administrator on 10/12/21 at 3:24 PM who stated Resident #30 was assessed as a safe smoker in June 2022. She explained that a resident deemed as a safe and independent smoker should be assessed monthly per facility policy. The Administrator reviewed Resident #30's record during this interview and verified Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 70	F 689		

#30 was not assessed for smoking in July, August, or September 2022 and should have been assessed each month according to facility policy before being allowed to continue to smoke each month. The Administrator stated Resident #30's care plan was not updated to match her smoking assessment. She reported the level of supervision required by Resident #30 was based on Resident #30's physical abilities on a daily basis.

3. Resident #4 was admitted to the facility on 06/17/21.

Resident # 4's record review revealed there was no smoking assessment completed.

Review of Resident #4's annual Minimum Data Set (MDS) dated 05/26/2022 revealed he was cognitively intact and coded as a tobacco user.

Further record review of Resident #4's most current care plan dated 06/06/22 revealed he was care planned as a safe and independent smoker.

Observation on 10/11/22 at 1:28 pm revealed Resident #4 was smoking in the facility's designated smoking area. Continuous observation also revealed there was not a staff person in the smoking area during this time.

Interview with Resident #4 on 10/14/22 at 10:31 am revealed he smoked every day and had been smoking since his admission to the facility on 06/17/21. Resident #4 also stated he kept his smoking materials in his room or on his person until 10/11/22 when the facility informed him his smoking materials would be kept at the nurse's station until he requested to go outside to smoke.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 71	F 689		

An interview with the Administrator on 10/14/2022 at 11:39 am revealed a smoker's assessment had not been completed for Resident #4. The Administrator also looked up Resident #4's medical chart during this interview and stated Resident #4 should have been assessed using the smoker's assessment prior to being allowed to smoke. The Administrator also stated nurses are responsible for conducting the smoker's assessment.

4. Resident #24 was admitted to the facility on 08/12/21.

Resident #24's record review revealed monthly smoking assessments were not completed during the months of July, August, and September 2022. Resident #24's last documented smoker's assessment dated 06/01/22 revealed she was assessed as a safe and independent smoker

Review of Resident #4's annual Minimum Data Set (MDS) dated 05/26/2022 revealed she was coded as a tobacco user.
Further record review of Resident #24's care plan dated 08/12/22 revealed she was care planned as a safe and independent smoker.

Observation on 10/10/22 at 3:57 pm revealed Resident #24 was smoking in the facility's designated smoking area. Continuous observation revealed there was not a staff member present for this observation.

Interview with Resident #24 on 10/11/22 at 11:16 am revealed she smoked a few times every day and had been a smoking at the facility since her admission in 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 72 An interview with the Administrator on revealed a resident deemed as a safe and independent smoker should be assessed monthly per facility policy. The Administrator also stated nurses are responsible for conducting the smoker's assessment. The Administrator looked up Resident #24's medical chart during this interview and stated Resident #24 was not assessed for smoking in July, August, or September 2022 and should have been assessed each month according to facility policy before being allowed to continue to smoke each month.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 690	Continued From page 73 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interviews and staff interviews, the facility failed to attach urinary catheter tubing to a secure device to prevent tension and possible injury to the resident for 2 of 3 residents (Resident #69 and Resident #47) reviewed for urinary catheters. Findings included: 1. Resident #69 was admitted to the facility on 9/22/2022, and diagnoses included osteomyelitis of sacral ulcer and sacrococcygeal vertebrae. The admission Minimum Data Set (MDS) assessment dated 9/27/2022 indicated Resident #69 was cognitively intact, required assistance with toileting and used an indwelling catheter for elimination of urine. Resident #69's care plan included a focus for an altered pattern of urinary elimination with an indwelling catheter due to being at risk for infection related a stage 4 sacral pressure ulcer with osteomyelitis. Interventions included catheter care per facility protocol.	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI Resident #47 no longer resides in the facility. On 11/3/22, the nurse applied a catheter secure strap to the thigh of resident #69 to secure foley catheter tubing to prevent tension and possible injury to the resident. On 10/11/22, the Director of Nursing completed an audit of all residents with urinary catheters to include resident #69. This audit is to ensure Foley catheter tubing is secured to the upper thigh to prevent tension and possible injury to resident. There were no additional concerns identified during the audit. On 11/7/22, the Assistant Director of Nursing and Director of Nursing initiated an in-service with all nurses and nursing assistants regarding Urinary Catheters with emphasis on ensuring catheter tubing is secured to prevent tension and possible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 690	Continued From page 74 A review of the physician's orders reviewed no order for the use of a secured device with an indwelling urinary catheter. On 10/10/2022 at 10:40 a.m. in an interview with Resident #69, she stated she had a urinary catheter to prevent her sacral wound dressing from getting soiled with urine and stated the indwelling urinary catheter created a pulling sensation at times. Resident #69 was able to uncover and expose her upper thigh area. There was no secure device observed on either thigh area. The indwelling urinary catheter was observed lying on top of Resident #69's right thigh. On 10/11/2022 at 9:30 a.m., Nurse Aide (NA) #5 was observed preparing to bathe Resident #69. When NA #5 exposed Resident #69's right thigh, the indwelling urinary catheter was observed underneath the right thigh and there was no secure device observed to attach the urinary catheter. On 10/11/2022 at 9:31 a.m. in an interview with NA #5, she stated a secured device or strap was used to hold and prevent the indwelling urinary catheter from pulling on the resident. She stated nurses and nurse aides applied the secure device for indwelling urinary catheter as needed and would apply a secured device for Resident #69 after the completion of her bath. On 10/13/2022 at 1:45 p.m. In an interview with Nurse #1, he stated Resident #69 needed a secure device to attach the indwelling urinary catheter to prevent pulling of the urinary catheter. He stated the secure device would fall off, and nurses and nurse aides were to assure the	F 690	injury to the resident. The in-service will be completed by 11/23/22. After 11/23/22, any nurse or nursing assistant who has not worked or received the in-service will complete upon next scheduled work shift. All newly hired nurses and nursing assistants will be in-service during orientation regarding Urinary Catheters. The Central Supply Clerk will complete an audit of all residents with urinary catheters to include resident #69 weekly x 4 weeks then monthly x 1 month utilizing the Urinary Catheter Audit Tool. This audit is to ensure Foley catheter tubing is secured to include leg drainage bags are positioned below bladder level to prevent urinary tract infections. The Central Supply Clerk will address all concerns identified during the audit to include Foley catheter tubing being secured and if needed repositioning of drainage bag and education of staff. The DON will review the Urinary Catheter Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. DON will forward the results of the Catheter Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months to review the Catheter Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 690	Continued From page 75	F 690		

indwelling urinary catheter was attached to the secure device when providing care and reapply the secure device as needed.

On 10/13/2022 at 5:15 p.m. in an interview with Nurse #4, she stated secure devices and leg straps were available in the facility that staff used to secure indwelling urinary catheters to prevent tension on the tubing. She stated it was the responsibility of nurses and nurse aides to assess and assure Resident #69's indwelling urinary catheter was attached to a secured device and re-apply as needed.

On 10/14/2022 at 5:54 p.m. in an interview with the Administrator, she stated indwelling urinary catheters were to be secured with the use of a secure device.

2. Resident #47 was admitted to the facility on 9/5/22 with diagnoses including flaccid neuropathic bladder and atrial fibrillation.

The admission Minimum Data Set (MDS) dated 9/11/22 indicated Resident #47 had moderate cognitive impairment, required assistance with activities of daily living and had an indwelling urinary catheter.

On 10/10/22 at 12:11 PM and interview was conducted with Resident #47. He stated he had a urinary catheter but did not have a leg strap in place to hold it. Resident #47 was able to pull his covers back exposing the catheter tubing crossed over the right thigh and no catheter strap was observed.
On 10/12/22 at 11:30 AM a second interview was conducted with Resident #47, and he stated he did not have a catheter strap attached to his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 690	Continued From page 76 thigh. He was able to expose both his upper legs and no catheter strap was observed. NA #9 was interviewed on 10/12/22 at 11:41 and she stated she was working at the facility through an agency. She stated she does catheter care on residents, but she does not make sure a catheter strap in in place An interview was conducted with NA #10 on 10/12/22 at 11:44 AM and she stated when she did catheter care and didn't see a catheter strap, she would let the nurse know. On 10/12/22 at 11:48 AM an interview was conducted with Nurse #9, and she stated when she assessed a urinary catheter, she did look to see if the catheter leg strap was in place. Nurse #9 stated Resident #47 should have a leg strap in place. DON #2 was interviewed on 10/12/22 at 11:55 AM and she stated every resident who had a urinary catheter should have a leg strap in place.	F 690		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 725	Continued From page 77 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to allocate sufficient staff to answer call bells (Resident #172), perform wound care (Resident #69) and perform smoking assessments. The findings included: 1. This tag is cross referenced to F550. Based on record review and staff interviews, the facility failed to promote dignity by delaying answering a call bell device for 1 of 4 residents reviewed for dignity. (Resident #172) 2. This tag is cross-referenced to F686. Based on record review, resident interview and staff interviews, the facility failed to perform wound care as physician ordered to a pressure ulcer injury for 1 of 2 residents reviewed with pressure ulcer injuries. (Resident #69) An observation was conducted on 10/10/12 at 5:31 PM and there was no one at the center nursing station. Director of Nursing (DON) #1 stated there was not a nursing supervisor	F 725	F725 Sufficient Nursing Staff On 10/27/22, the Administrator reviewed the daily staff sheet and determined there was sufficient staffing to meet resident needs to include but not limited to providing wound care per physician order, assessing residents for smoke safety when indicated and promoting resident dignity and respect by promptly responding to call light and addressing resident care needs. On 10/27/22, the Administrator reviewed the clinical staffing schedule for the next 7 days. This review is to ensure sufficient staff were scheduled to meet the care needs of the residents to include but not limited to sufficient to provide wound care per physician order, assessing residents for smoke safety when indicated and promoting resident dignity and respect by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 725	Continued From page 78 assigned. She reported there was not a permanent nursing supervisor assigned on day shift. DON #1 reported she felt that staffing levels were beginning to improve but had difficulties during the pandemic. An interview was conducted with the Corporate Nursing Consultant on 10/11/22 at 3:06PM. She reported the nursing supervisors were placed on medication carts to meet the needs of the facility. An interview was conducted with Nurse Aide (NA) #5 on 10/12/22 at 2:35 PM. She reported that due to call outs she was not able to get all her tasks completed. NA #5 stated some of residents did not get shaved on 10/10/22 because she did not have time. An interview was conducted with the Assistant Director of Nursing (ADON) on 10/13/22 at 2:50 PM. She reported she started her position as ADON on 9/13/22. The ADON reported due to staffing second shift supervisors were having to work medication carts instead of their other duties. She reported the facility continued to utilize agency staff. The ADON stated the facility was recruiting via employment websites and word of mouth. An interview was conducted with Nurse #10 on 10/14/22 at 1:35 PM she reported there was too much work to do on the weekends. She stated she was not able to get wound care done when also being on a medication cart and dealing with admissions and emergencies. Nurse #10 stated families would assist the aides to pass meal trays on the weekends to ensure the trays were delivered timely. She further stated she did not feel there were enough staff on the weekends to	F 725	promptly responding to call light and addressing resident care needs. The Administrator and Director of Nursing (DON) will address all concerns identified during the audit. Audit will be completed by 11/23/22. On 11/1/22, the Administrator verified the facility contracts with staffing agencies. The facility will utilize agency staffing to ensure daily staffing is sufficient to meet the care needs of the residents to include but not limited to sufficient to provide wound care per physician order, assessing residents for smoke safety when indicated and promoting resident dignity and respect by promptly responding to call light and addressing resident care needs. On 11/7/22, the Facility Nurse Consultant in-serviced the Administrator, DON and Scheduler regarding Sufficient Staff with emphasis on staffing expectations and ensuring the schedule is reviewed daily for adequate staffing patterns. The Administrator and DON must ensure sufficient staff based on the staff□s ability to provide needed care to residents that enable them to reach their highest practicable physical, mental, and psychosocial well-being. All newly hired Administrators, DON, and schedulers will be in-serviced during orientation regarding Sufficient Staff. The Administrator/DON will audit staffing schedule 5 times a week include nights and weekends x 4 weeks then then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 725	Continued From page 79 meet the needs of residents. During an interview with the Administrator on 10/14/22 at 5:10 PM she stated she felt staffing was sufficient.	F 725	monthly x 1 month utilizing the Sufficient Staff Audit Tool. This audit is to ensure daily staffing is sufficient to meet the care needs of the residents to include but not limited to sufficient to provide wound care per physician order, assessing residents for smoke safety when indicated and promoting resident dignity and respect by promptly responding to call light and addressing resident care needs, and to ensure the residents reach their highest practicable physical, mental and psychosocial well-being. All areas of concern will be immediately addressed by the DON/Administrator to include use of administrative nurses pulled to the hall to meet resident care needs. The Administrator will initial the Sufficient Staff Audit Tool daily to all concerns were addressed. The Director of Nursing will present the results of the Sufficient Staff Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly x 2 months. The QAPI Committee will meet and review the Sufficient Staff Audit Tool monthly x 2 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	F 755		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 755	Continued From page 80 drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to establish a secured and effective system to contain and record control drugs to be returned to the pharmacy for a discharge resident (Resident #174) 1 of 1 discharged resident (Resident #174) reviewed for returning control drugs to the pharmacy.	F 755	F755 Pharmacy Resident #174 no longer resides in the facility. All medications for resident #174 have been returned to the pharmacy. On 10/18/22, the Director of Nursing and Assistant Director of Nursing initiated an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 755	Continued From page 81 Findings Included: The pharmacy's "Procedure for Returning Controlled Substance dated 06/2021 stated facility staff members must complete the Return of Drugs Form and place the medications in a self-sealing controlled bag and document the serial number on the Return of Drugs form. The sealed bag of medication and the Return of Drugs form shall be kept locked in the controlled substance locked drawer of the medication cart until the courier arrives for pick up. Return of Drugs must be faxed to the pharmacy before 4 p.m. for pick up that evening and forms received after 4:00 p.m. would be accepted by the courier on the following business day. 1. Resident #174 was admitted to the facility on 11/23/2021, and diagnoses included chronic pain. Physician orders dated 11/23/2021 revealed Resident #174 was ordered Oxycodone-Acetaminophen 7.5-325 milligrams one tablet orally every four hours as needed for pain. A review of the November 2022 Medication Administration Record revealed Resident #174 received Oxycodone-Acetaminophen 7.5-325 milligrams one tablet last on 11/30/2021 at 5:37 a.m. A review of a written statement dated 12/13/2021 at 8:28 p.m. by Nurse #13 revealed on 12/2/2021, Nurse #13 prepared Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets to return to the pharmacy. She stated there were thirty Oxycodone-Acetaminophen 7.5-325 milligrams tablets in two packs and	F 755	audit of all medication carts and medication prep rooms for medications that have been discontinued or for any medications of residents who have been discharged to include control substances. This audit is to ensure a secured and effective system to contain and record control drugs returning to pharmacy was in place, the nurse followed facility protocol when returning medications to include controlled substances and that medications were returned to the pharmacy timely. Audit will be completed by 11/23/22. On 11/7/22, the Assistant Director of Nursing and Director of Nursing initiated an in-service with all nurses regarding Medication Disposition Guidance with emphasis on (1) process for containing and returning control drugs (2) process for returning medications other than controlled substances (3) notification of pharmacy if medications are not picked up timely. The in-service will be completed by 11/23/22. After 11/23/22, any nurse who has not worked or received the in-service will complete upon next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Medication Disposition Guidance. The Assistant Director of Nursing and assign hall nurse will review medication carts and medication prep room weekly x 4 weeks then monthly x 1 month utilizing the Return of Drugs Form. This audit is to ensure a secured and effective system to contain and record control drugs returning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 755	Continued From page 82 twelve Oxycodone-Acetaminophen 7.5-325 milligrams tablets in one pack for a total of seventy-two Oxycodone-Acetaminophen 7.5-325 milligrams tablets. Nurse #13 stated the unsealed bag of Oxycodone-Acetaminophen 7.5-325 milligrams tablets was placed in the narcotic box on the 100-medication cart with the narcotic sheets to conduct narcotic counts until pharmacy picked up the medication. She stated upon returning to work on 12/4/2021, Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets were observed in a sealed bag in the narcotic box and Nurse #6 was notified. In a written statement dated 12/15/21 by Nurse #6, she stated on 12/4/2021, pharmacy had not picked up Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets, and the medications were in a sealed bag with the paper requiring signatures when pharmacy picked up the medication located also inside the sealed bag. She stated Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets were in the narcotic box for pharmacy to pick up. On 12/12/2021, Nurse #6 stated Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets were observed still on the medication cart and informed the day shift staff to send the medication back to pharmacy. Nurse #6 stated she did not notice any loose tablets in Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets package on 12/4/2021 or 12/12/2021. In a written statement dated 12/15/2021 by Nurse #14, she stated on 12/2/2021 she relieved Nurse #15 on 100-medication cart, and Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams	F 755	to pharmacy was in place, the nurse followed facility protocol when returning medications to include controlled substances and that medications were returned to the pharmacy timely. The Assistant Director of Nursing and assign hall nurse will address all concerns identified during the audit to include securing controlled substances immediately when indicated, completion of return of drug form for all medications to be returned to pharmacy, notification of pharmacy for pick up and re-training of staff. The Director of Nursing will review the Return of Drug Form weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will present the results of the Return of Drug Form to the Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly x 2 months. The QAPI Committee will meet and review the Return of Drug Form monthly x 2 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 755	Continued From page 83	F 755		

tablets were in a sealed package. Nurse #15 informed her the medication was to be returned to the pharmacy. She stated the two nurses did not verify the count of Oxycodone-Acetaminophen 7.5-325 milligrams tablets in the sealed bag and did not notice any loose tablets.

In a written statement dated 12/16/2021 by Nurse #15, she stated she worked 12/2/2021 on the 100-medication cart and did not recall seeing or being notified of any medications for Resident #174 needing to be returned to the pharmacy.

In a written statement dated 12/14/2021 by Nurse #16, she stated on 12/8/2021 Nurse #17 asked if pharmacy had picked up Resident #174's controlled substances, and Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets were observed in the third narcotic compartment used to store cigarettes and lighters only. She observed two sealed bags of narcotics and instructed Nurse #17 to have the nursing supervisor to unseal the bag of narcotics and refax to pharmacy for pick up.

In a written statement by Nurse #18 not dated, Nurse #18 stated she worked on 12/3/2021 and did not recall seeing Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets. Nurse #18 stated she later (date unknown) observed the medication rolled up in the third narcotic box on the 100-medication cart. She stated she was informed it took a while for pharmacy to pick up the medications, and Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets were left in the narcotic box. She stated the medication package was not opened and not counted for verification of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 755	Continued From page 84	F 755		

number of tablets in the package.

In a written statement dated 12/13/2021 by Nurse #8, who worked 7:00 p.m. to 7:00 a.m. shift on 12/13/2021, he stated on 12/13/2021 he collected controlled substances from the split hall medication cart to prepare for return to the pharmacy and noticed loose medication in Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets package. With another staff member, the narcotic count for Resident's Oxycodone-Acetaminophen 7.5-325 milligrams tablets was verified at sixty-eight. There were sixty-six in the packs and two loose tablets. The narcotic count sheet reflected seventy-two Oxycodone-Acetaminophen 7.5-325 milligrams tablets were to be present. Nurse #8 notified the Director of Nursing who returned to the facility for further investigation.

A review of the facility's initial report dated 12/13/2021 at 8:47 p.m. revealed four of Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets were potentially missing. The local law enforcement agency was notified on 12/13/2021 at 9:00 a.m., and the facility's initial report was submitted by fax to the state regulatory agency on 12/14/2021 at 12:12 p.m.

The investigation report dated 12/21/2022 revealed there were four missing Oxycodone-Acetaminophen 7.5-325 milligrams tablets from Resident #174's supply of controlled substances. Resident #174 was discharge on 11/30/2021 and no physical harm had occurred to Resident #174. Nursing interviews and drug tests for all potential staff involved were conducted, and nurses were in-serviced on drug diversion and returning controlled substances to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 755	Continued From page 85	F 755		

pharmacy. All controlled substances on the medications carts and in narcotic boxes were audited with no issues identified.

A review of the pharmacy's Control Substance Documentation Inspection form dated 1/20/2022 did not address returning controlled substances of discharged residents on the audit.

On 10/13/2022 at 2:07 p.m. in a phone interview with the Director of Nursing #2, she stated returning controlled substances to the pharmacy consisted of packaging the controlled substances, completing and faxing a Controlled Narcotic to Pharmacy form to the pharmacy and pharmacy picking up the controlled substance. She stated controlled substances were to be sent back to the pharmacy the day of a resident's discharge. She stated Resident #174's controlled substances were not returned on the day of his discharge because the discharging nurse did not complete the Controlled Narcotic to Pharmacy form, and the pharmacy delivery person did not ask for the controlled substances after the Controlled Narcotic to Pharmacy form was completed and faxed to the pharmacy. She stated nursing staff were to count the controlled substances stored in the narcotic box until the controlled substance is returned to the pharmacy, and Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets did not have a Controlled Substance Count sheet in the bag with the controlled substances. She stated she was unable to identify when Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets bag was sealed and who sealed the bag. She stated a drug diversion was substantiated for Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets, and Resident #174's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 755	Continued From page 86	F 755		

Oxycodone-Acetaminophen 7.5-325 milligrams tablets should had been sealed with the Controlled Narcotic to Pharmacy form attached to the outside of the bag in the narcotic box while awaiting pharmacy to pick up.

On 10/13/2022 at 2:50 p.m. in a phone interview with Nurse # 6, she stated she could not recall whether Resident's 174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets were in a sealed or unsealed package. She stated controlled substances did not have to be returned to the pharmacy immediately after discharge of a resident and stated she waited until there were three to four controlled substances needing to be returned to the pharmacy, counted the controlled substances with another nurse and sealed in a bag, completed and faxed the Controlled Narcotic to Pharmacy form to pharmacy and confirmed pharmacy picked up the controlled substances. She stated it was not unusual to go weeks without sending controlled substances back to the pharmacy after a resident was discharged and stated if controlled substances were not picked up after pharmacy was notified, a second request for Controlled Narcotic to Pharmacy was sent to the pharmacy. She stated controlled substances in unsealed bags stored in the narcotic box on the mediation carts were counted by two nurses at the change of shift for verification of the number of controlled substances.

On 10/13/2022 at 3:47 p.m. in a phone interview with the pharmacy's Regional Clinical Manager, she stated the pharmacy received a fax on 12/2/2021 notifying the pharmacy Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets were to be returned to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 755	Continued From page 87	F 755		

pharmacy, and on 12/13/2021, the pharmacy received another fax indicating Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets were to be returned to the pharmacy and some of the medication was missing. She stated there were no records indicating why the narcotics were not picked up by the pharmacy on 12/2/2021 initially as requested and stated there was no specific time frame on when to return controlled substances or medications to the pharmacy after a resident was discharged. She stated the pharmacy recommended securing medications and controlled substances in the medication room when a resident was discharged because residents would return to the facility on the same orders and the medications would be available for the resident. She stated the pharmacy changed the Controlled Narcotic to Pharmacy form to include a section for an explanation when controlled substances were not picked up at the facility by the pharmacy courier.

On 10/13/2022 at 3:02 p.m. in an interview with Nurse #8, he stated controlled substances waiting to be returned to the pharmacy were stored in different places: on the split-hall medication cart between 100 and 200-hall, the medication cart assigned to the resident's hall and in a box in the medication room. He stated the pharmacy was notified to pick up controlled substances by completing and faxing a Controlled Narcotic to Pharmacy form to the pharmacy, and the pharmacy delivered medications to the facility daily. He stated on 12/13/2021, he noticed a loose tablet in Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams bag, and when the medication was counted, the number of Oxycodone-Acetaminophen 7.5-325 milligrams tablets did not match the number on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 755	Continued From page 88	F 755		

the control substance count sheet. He stated the Director of Nursing was notified, the Control Narcotic to Pharmacy form was faxed to the pharmacy, and Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets were picked up by the pharmacy on 10/14/2021. He stated for discharged residents, control substances were to be returned to the pharmacy the same day and for residents sent to the hospital, medications were not returned to the pharmacy. Nurse #8 stated there was no change in the process to return controlled substances to the pharmacy, and when controlled substances were in a sealed bag, nurses did not count the controlled substance. He stated if the controlled substances were not in a sealed bag, two nurses counted the controlled substance. He further stated the reason Resident #174's controlled substances were not returned to the pharmacy after his discharge was because the contracted staff did not know Resident #174 was discharge.

On 10/13/2022 at 4:53pm in an interview with Nurse #3, she stated discharged resident's controlled substances were stored in the narcotic box until the pharmacy picks up during the night, and Resident #174's controlled substances were count by two nurses and placed in a sealed bag, the Controlled Narcotic to Pharmacy form was completed and faxed to the pharmacy so the controlled substances could be pickup up by the pharmacy courier that night.

On 10/13/2022 at 5:20 p.m. in an interview with Nurse #4 with the Interim Director of Nursing (DON) #3 present, Nurse #4, who had been with the facility for six weeks, stated the time frame controlled substances were returned to the pharmacy was determined by the facility's policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 755	Continued From page 89	F 755		

and discharged resident's controlled substance needed to be returned as soon as possible. She stated the process for returning controlled substances consisted of placing the controlled substances in a sealed bag for pharmacy to pick up as soon as possible and if the controlled substances were not picked up by the pharmacy, the nurse was to notify the Assistant DON or the DON that the controlled substances were not returned to the pharmacy. She stated part of the discharge checklist included returning controlled substances and medications appropriately to the pharmacy.

On 10/14/2021 at 7:47 a.m. in a phone interview with Nurse #13, she stated she did not work at the facility often and recalled receiving an orientation that included returning medications to the pharmacy prior to working. She stated she could not recall all the details of the incident with Resident #174's Oxycodone-Acetaminophen 7.5-325 milligrams tablets. She stated she recalled Resident #174 was not at the facility, and she counted the narcotics with another nurse and completed and faxed the Controlled Narcotic to Pharmacy form to the pharmacy. She stated Resident #174 Oxycodone-Acetaminophen 7.5-325 milligrams tablets were in a sealed bag when returned to the medication cart for pharmacy to pick up.

On 10/14/2022 at 9:30 a.m. in an interview with Nurse #1, he stated the facility had provided in-services to the nursing staff on returning controlled medications to the pharmacy. When asked how controlled substances were returned to the pharmacy, he stated other staff members returned controlled medications to the pharmacy, and controlled medications were returned to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 755	Continued From page 90 pharmacy on the night shift. On 10/14/2022 at 6:00 p.m. in an interview with the Administrator, she stated the nurses were to follow the policy in returning controlled substances to the pharmacy after a resident was discharged.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 758	Continued From page 91 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and Medical Director interview, the facility failed to implement a 14-day stop date for an as needed psychotropic medication for 1 of 5 resident's reviewed for unnecessary medications (Resident #52). Findings included: Resident #52 was admitted to the facility on 06/08/21 with diagnoses which included restlessness and agitation. Resident #52's physician order dated 09/27/22 revealed he was ordered lorazepam 2 milligram (mg) per one milliliter (ml) inject 0.5 mg intramuscularly (IM) every eight hours as needed for agitation with a stop date of indefinite. A review of the Medication Administration Record	F 758	F758 Free of Unnecessary Psychotropic Meds/PRN use On 10/14/22, the PRN Ativan order for resident #52 was discontinued per physician order. On 10/17/22, the Pharmacy consultant initiated an audit of all PRN psychotropic medications to ensure PRN psychotropic medications for all residents to include resident #52 were limited to a duration of 14 days unless the attending physician or prescribing practitioner documented the rational for the extended time period in the medical record and indicated the specific duration. The pharmacy recommendations were forward to the physician for all concerns identified during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 758	Continued From page 92 (MAR) for Resident #52 revealed he had not received lorazepam 0.5 mg intramuscularly. Attempts were made to reach the Pharmacist Consultant but were unsuccessful. An interview with the Medical Director on 10/14/22 at 11:10 am revealed she wrote the order for lorazepam IM without a stop date by accident and didn't put a stop date. The Medical Director further stated on the day she wrote the order for lorazepam; Resident #52 was very agitated. She also stated the lorazepam order for Resident #52 should have had a stop date of no more than 14 days.	F 758	the audit. The audit will be completed by 11/23/22. On 11/7/22, the Assistant Director of Nursing and Director of Nursing initiated an in-service will all nurses and providers regarding PRN Psychoactive Medication Monitoring with emphasis on limiting the duration of PRN psychotropic medication use to a duration of 14 days unless the attending physician or prescribing practitioner documents the rational for the extended time period in the medical record and indicates the specific duration. In-service will be completed by 11/23/22. After 11/23/22, any nurse or provider who has not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses and/or providers will be in-serviced during orientation regarding PRN Psychoactive Medication Monitoring. 10% audit of all residents to include resident #52 physician orders for PRN psychotropic medications will be reviewed by the Director of Nursing weekly x 4 weeks then monthly x 1 month utilizing the Psychoactive Medication Audit Tool. This audit is to ensure that the duration of the psychotropic medication is limited to 14 days unless the attending physician or prescribing practitioner documented the rational for the extended time period in the medical records. The Director of Nursing will obtain a clarification order from the physician and retrain the nurse for any identified areas of concerns during the audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 758	Continued From page 93	F 758	The DON will present the findings of the Psychoactive Medication Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Psychoactive Medication Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 761	Continued From page 94	F 761		

be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation, resident interview, and staff interviews, the facility failed to 1.) date two opened medications for 1 of 2 medication carts used for medication administration on 100 Hall and 2.) store medication in a locked cabinet for 1 of 1 resident reviewed for medication administration. (Resident # 172).

Findings included:

1. On 10/14/2022 at 8:43 am, observation of the medication administration cart known as "100-Hall" with Nurse #2 revealed the following medications were open and without an open date: budesonide 0.5milligram/2milliliters foil pack with four of five single doses which had a sticker that read, "expires 2 weeks after opening" with a pharmacy delivery date of 09/21/2022 for Resident #70 and one timolol 0.25% eye drop bottle with the seal broken and approximately half full for Resident #272.

An interview with Nurse #2 on 10/14/2022 at 8:45 am revealed there should be an open date on all opened medications. She further stated any medications opened without a written date of when the medication(s) were opened should be thrown away and contact pharmacy to order the mediation(s).

An interview with the Assistant Director of Nursing (ADON) on 10/14/2022 at 9:46 am revealed all medications, including foil packs and eye drops, should be dated at the time the seal is broken and should be discarded if opened and there is

F761 Label/Store Drugs and Biologicals

On 10/18/22 the DON removed and destroyed all medications that were not labeled with an open date and/or expiration date to include inhaler foil packs and/or eye medications and any expired medications from the 100 hall medication cart per facility protocol.

On 10/10/22, medication (Tylenol) and nystatin cream removed from resident #172 room and discarded.

On 10/18/22, the Director of Nursing an audit of all medication carts and medication rooms to ensure the nurse and/or medication aid labeled medication with an open date/expiration date when indicated, expired medications are removed and destroyed per facility protocol and/or returned to the pharmacy timely for destruction, and that all carts were locked when not supervised by assigned nurse. The DON will address all concerns identified during the audit to include labeling mediations with an open date/expiration date when indicated, removing expired medications per facility protocol, returning expired or discontinued medications to the pharmacy for destruction when indicated and locking medication cart. The audit will be completed by 11/23/22

On 10/17/22, the Administrator initiated an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 761	Continued From page 95 not an open date written on the medication. The Director of Nursing was not available for interview. An interview with the Administrator on 10/14/2022 at 3:47 PM revealed all opened medications must be dated at the time it is opened or the seal is broken. 2. Resident #172 was admitted to the facility on 9/30/2022. Physician orders revealed an order dated 10/4/2022 for Acetaminophen 650 milligrams (mg) orally three time a day for osteoarthritis, and Nystatin cream ordered on 10/10/2022 100,000 units/gram to apply underneath breast topically twice a day for fungal rash. The Admission Minimum Data Set (MDS) Assessment dated 10/6/2022 indicated Resident #172 was cognitively intact. The October 2022 Medication Administration Record revealed Acetaminophen was scheduled three times a day at 8:00 a.m., 12:00 p.m. and 8:00 p.m. Nurse #1 recorded Resident #172's pain level as zero and Acetaminophen as given at 8:00 a.m. on 10/10/2022 on the MAR. Nystatin cream was scheduled twice a day at 8:00 a.m. and 8:00 p.m., and Nurse #1 recorded the medication as given at 8:00 a.m. on 10/10/2022. On 10/10/2022 at 11:28 a.m. two medication cups were observed on the overbed table positioned on the right side of the bed. Two white scored tablets with the numbers 54 and 27 identified on the tablets were observed in one medication cup	F 761	audit of all resident rooms. This audit is to ensure medications were not left at resident bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. The assigned nurse will address all concerns identified during the audit to include removal of medications when indicated and education of staff. Audit will be completed by 11/23/22. On 11/7/22, the Assistant Director of Nursing and Director of Nursing initiated an in-service with all nurses and medication aides regarding (1) Medication Storage with emphasis on labeling medications with an open date/expiration date per facility protocol, responsibility to check medication cart/medication storage room daily for expired medications and discarding expired medications per pharmacy policy and (2) Rights of Medication Administration with emphasis on administering medication per physician order to include right medication at the right time and not leaving medication at bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. In-services will be completed by 11/23/22. After 11/23/22 any nurse or medication aide who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses or medication aides will be in-serviced during orientation regarding Medication Storage and Rights of Medication Administration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 761	Continued From page 96 and untouched rows of beige colored cream was observed in the other medication cup. On 10/10/2022 at 11:29 a.m. in an interview with Resident #172, she stated the tablets were Acetaminophen, a pain medication, and the cream was for chapped skin underneath her breast. She stated the medications were left by the nurse that morning. She stated she was not in pain and did not know why the nurse did not apply the cream underneath her breast. On 10/10/2022 at 11:48 a.m., Nurse #4 was observed entering Resident #172's room to answer a call device. When she inquired about the medications in the medication cups on the over bed table, Resident #172 stated "those medications were given to her that morning to take." Nurse #4 was observed exiting Resident #172's room with the two medication cups in her hand. On 10/10/2022 at 11:50 p.m. in an interview with Nurse #4, she stated the two medication cups with medications inside should not have been left on the over bed table. She stated when administering medications, nurses should make sure Resident #172 had taken the medication and if Resident #172 did not take the medication, the medication should be disposed. On 10/11/2022 at 10:00 a.m. in an interview with Nurse #1, who was assigned to Resident #172 on 10/10/2022, he stated he didn't observe any medications on the overbed table at the bedside for Resident #172 on 10/10/2022, if he had, he would have removed the medication from the room. He stated he administered Resident #172 her Acetaminophen and Nystatin cream under the	F 761	The Assistant Director of Nursing will audit all medication carts weekly x 4 weeks then monthly x 1 month utilizing the Medication Cart Audit Tool. This audit is to ensure the nurse and/or medication aid labeled medication with an open date/expiration date when indicated, expired medications are removed and destroyed per facility protocol, and that all carts were locked when not supervised by assigned nurse. The DON will address all concerns identified during the audit to include labeling mediations with an open date/expiration date when indicated, removing expired medications per facility protocol and locking medication cart. The Director of Nursing (DON) will review Medication Cart Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. for completion and to ensure all areas of concerns were. The Activity Director will audit resident rooms utilizing resident census sheet weekly x 4 weeks then monthly x 1 month. This audit is to ensure the nurse and/or medication aid did not leave medication at bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. The Activity Director and assign nurse will address all concerns identified during the audit to include but not limited to education of staff. The DON will review the med pass audits weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 761	Continued From page 97 breast on 10/10/2022. He further stated when residents didn't take medications as prescribed, nurses chart resident refused and dispose of the medication. On 10/11/2022 at 3:02 p.m. in an interview with the Interim Director of Nursing, she stated Resident #172 was not assessed to self-administer her own medications. She stated Resident #172's medications should not had been left at the bedside, and medications not taken by Resident #172 should be removed from the room. On 10/14/2022 at 5:50 p.m. in an interview with the Administrator, she stated Resident #172's medications should not had been left at the bedside. 2. Resident #172 was admitted to the facility on 9/30/2022. Physician orders revealed an order dated 10/4/2022 for Acetaminophen 650 milligrams (mg) orally three time a day for osteoarthritis, and Nystatin cream ordered on 10/10/2022 100,000 units/gram to apply underneath breast topically twice a day for fungal rash. The Admission Minimum Data Set (MDS) Assessment dated 10/6/2022 indicated Resident #172 was cognitively intact. The October 2022 Medication Administration Record revealed Acetaminophen was scheduled three times a day at 8:00 a.m., 12:00 p.m. and 8:00 p.m. Nurse #1 recorded Resident #172's pain level as zero and Acetaminophen as given at 8:00 a.m. on 10/10/2022 on the MAR. Nystatin	F 761	The DON will present the findings of the Medication Cart Audit Tool and Room Audits to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Medication Cart Audit Tool and Room Audits to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 761	Continued From page 98	F 761		

cream was scheduled twice a day at 8:00 a.m. and 8:00 p.m., and Nurse #1 recorded the medication as given at 8:00 a.m. on 10/10/2022.

On 10/10/2022 at 11:28 a.m. two medication cups were observed on the overbed table positioned on the right side of the bed. Two white scored tablets with the numbers 54 and 27 identified on the tablets were observed in one medication cup and untouched rows of beige colored cream was observed in the other medication cup.

On 10/10/2022 at 11:29 a.m. in an interview with Resident #172, she stated the tablets were Acetaminophen, a pain medication, and the cream was for chapped skin underneath her breast. She stated the medications were left by the nurse that morning. She stated she was not in pain and did not know why the nurse did not apply the cream underneath her breast.

On 10/10/2022 at 11:48 a.m., Nurse #4 was observed entering Resident #172's room to answer a call device. When she inquired about the medications in the medication cups on the over bed table, Resident #172 stated "those medications were given to her that morning to take." Nurse #4 was observed exiting Resident #172's room with the two medication cups in her hand.

On 10/10/2022 at 11:50 p.m. in an interview with Nurse #4, she stated the two medication cups with medications inside should not have been left on the over bed table. She stated when administering medications, nurses should make sure Resident #172 had taken the medication and if Resident #172 did not take the medication, the medication should be disposed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 761	Continued From page 99 On 10/11/2022 at 10:00 a.m. in an interview with Nurse #1, who was assigned to Resident #172 on 10/10/2022, he stated he didn't observe any medications on the overbed table at the bedside for Resident #172 on 10/10/2022, if he had, he would have removed the medication from the room. He stated he administered Resident #172 her Acetaminophen and Nystatin cream under the breast on 10/10/2022. He further stated when residents didn't take medications as prescribed, nurses chart resident refused and dispose of the medication. On 10/11/2022 at 3:02 p.m. in an interview with the Interim Director of Nursing, she stated Resident #172 was not assessed to self-administer her own medications. She stated Resident #172's medications should not had been left at the bedside, and medications not taken by Resident #172 should be removed from the room. On 10/14/2022 at 5:50 p.m. in an interview with the Administrator, she stated Resident #172's medications should not had been left at the bedside	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an	F 791		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 791	Continued From page 100 outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews the facility failed to provide routine dental care for 1 of 1 resident reviewed for dental care (Resident #63).	F 791	F791 Routine/Emergency Dental Services On 11/7/22, resident #63 was interviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 791	Continued From page 101 Findings Included: Resident #63 was admitted to the facility on 7/14/21. The quarterly Minimum Data Set dated 9/28/22 revealed Resident #63 had moderate cognitive impairment. He was coded to have no issues with broken teeth and no facial or mouth pain. On 10/10/22 at 3:00 PM Resident #63 was interviewed and he stated he would like to see a dentist, but he had not seen the dentist since his admission to the facility. He stated he does not have any pain and does not have any trouble with eating. An observation at the same time of the interview of Resident #63's teeth revealed he had missing teeth, they were grayish in color, and his lower teeth appeared to be jagged. The Social Worker was not in the facility and was unavailable for interview. The Administrator was interviewed on 10/13/22 at 2:57 PM and she stated the facility utilized a dentist who came to the facility every 3 month and see residents. She stated a list of residents were provided for the dentist to see. She stated she did not see Resident #63's name on the lists of residents to be seen since his admission. A second interview was conducted with the Administrator on 10/15/22 at 12:28 PM and she stated she expected the residents to have routine dental care.	F 791	for dental pain or difficulty eating by the Administrator with no concerns identified. On 10/18/22, a dental appointment was scheduled for resident #63 for 11/4/22. Resident refused to attend appointment. On 10/17/22, the Administrator initiated an audit of all residents to ensure residents were offered or assisted in obtaining routine/emergency dental care per facility guidelines. The Administrator will address all concerns identified during the audit to include scheduling dental care appointments per resident preference. The audit will be completed by 11/23/22. On 11/7/22, the facility consultant initiated an in-service with the Director of Nursing, Social Worker and Medical Records Director regarding Dental Care with emphasis on ensuring residents are offered or assisted in obtaining routine/emergency dental care per facility guidelines. In-services will be completed by 11/23/22. After 11/23/22 any DON, Social Worker or Medical Records Director who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired DON, Social Worker or Medical Records Director will be in-serviced during orientation regarding Dental Care. The Medical Records Director will audit 10% resident charts weekly x 4 weeks then monthly x 1 month utilizing Dental Audit Tool. This audit is to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 791	Continued From page 102	F 791	residents were offered or assisted in obtaining routine/emergency dental care per facility guidelines. The Medical Records Director will address all concerns identified during the audit to include scheduling dental care appointments per resident preference. The Administrator will review the Dental Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Social Worker will present the findings of the Dental Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Dental Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 812	Continued From page 103 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard expired food stored for use in the dry goods storage room. This practice had the potential to affect 75 of 76 residents in the facility. Finding included: 1. On 10/10/2022 at 9:50 a.m. during the initial tour of the kitchen accompanied by the dietary manager, a large container of brown seasoning sauce with an expiration date written as 21, Jul 22 was observed in the dry storage area dated open on 12/3/21. On 10/10/2022 at 9:50 a.m. in an interview with Dietary Manager, she stated expiration date on the container of brown seasoning sauce was unclear as written. She stated food items with questionable expiration dates needed to be removed from the storage area and discarded the brown seasoning sauce. On 10/10/2022 at 2:20 p.m. in a follow up interview with the Dietary Manager, she stated the dietary staff used individual bags of sauce instead of using the brown seasoning sauce in the large container. She confirmed the expiration date of the brown seasoning sauce was July 21, 2022, was available for dietary staff use and based on expiration date should had been	F 812	F812 Procurement, Store/Prepare/Serve On 10/10/22, the Dietary Manager removed all expired items located in the dry storage area. On 10/10/22, the Dietary Consultant initiated an audit of all food storage areas. This audit is to ensure all food items were dated and/or expired items were discarded per facility protocol. The Dietary Consultant will address all concerns identified during the audit to include discarding food items when indicated and education of staff. On 10/10/22, The Dietary Manager initiated an in-service with all dietary staff regarding Dating Food Items with emphasis on ensuring items are dated per facility protocol and all expired items removed and discarded in accordance with professional standards for food service safety. In-service will be completed by 11/23/22. After 11/23/22 any dietary staff who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses or medication aides will be in-serviced during orientation regarding Dating Food Items.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 812	Continued From page 104 discarded. On 10/12/2022 at 8:58 p.m. in an interview with the Administrator, she stated expired foods in the kitchen were to be discarded.	F 812	The Dietary Consultant and/or Dietary Manager will audit all food storage areas weekly x 4 weeks then monthly x 1 month utilizing the Dietary Manager Daily Checklist. This audit is to ensure all food items in were dated and/or expired items were discarded per facility protocol. The Dietary Consultant and/or Dietary Manager will address all concerns identified during the audit to include removing all expired items and/or items not labeled per facility protocol and education of staff. The Administrator will review the Dietary Manager Daily Checklist weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Dietary Manager will present the findings of the Dietary Manager Daily Checklist. to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Dietary Manager Daily Checklist to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents	F 838		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 838	Continued From page 105	F 838		

competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 838	Continued From page 106 employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to include the facility medication aide in their facility assessment. The findings included: Review of the medication aide's employment dates revealed she was hired at the facility on 1/6/16 and transitioned to a medication aide on 5/22/22. Review of the facility schedules revealed she first worked as a medication aide on 7/4/22. Review of the facility assessment dated 8/19/22 revealed no mention of the facility medication aide, her competencies, or her certifications. This information would have been included in the facility's staffing plan. An interview with the Administrator on 10/12/22 at 4:05 PM revealed that the facility medication aide	F 838	F838 Facility Assessment On 10/14/22, the Administrator updated the facility assessment to include use of medication aides. On 10/14/22, the Administrator completed an audit of the facility assessment to ensure the assessment accurately reflects resources necessary to care for its residents to include but not limited to staff required for day to day operations. The Administrator will address all concerns identified during the audit to include updating assessment when indicated. On 11/7/22, the facility consultant initiated an in-service with the Administrator regarding Facility Assessment with emphasis on ensuring the assessment accurately reflects resources necessary to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 10/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 838	Continued From page 107 should have been included in the facility assessment if she was working as a medication aide at the time the annual facility assessment was completed. The Administrator indicated she was responsible for updating the facility assessment. During an interview with the Administrator on 10/14/22 at 5:00 PM she indicated the facility medication aide should have been included in the facility assessment.	F 838	care for residents during both day to day operations and emergencies, that assessment is reviewed and updated at least annually and/or with changes, and must include but not limited to resident census and facility capacity, resident care requirements, staff required and competencies, physical environment, equipment services, volunteers and health information technology. In-service will be completed by 11/23/22 The Regional Vice President and/or facility consultant will review the facility assessment monthly x 2 to ensure the facility assessment accurately reflects resources necessary to care for its residents to include but not limited to staff required for day to day and/or emergency operations. The RVP will address all concerns identified during the audit to include updating assessment when indicated and re-education of the Administrator. The Administrator will present the findings of the Facility Assessment Review to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Facility Assessment Review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	