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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	C 01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE NURSING AND REHABILITATION CENTER	711 SUSAN TART ROAD BOX 948 DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation completed on 1/10/13. Event ID # ODGM11.	F 000	Cornerstone 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. Cornerstone 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, Cornerstone 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	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews, the facility failed to provide an ongoing activities program for 1 of 3 sampled residents who were bed bound. (Residents # 6) The findings include: Resident # 6 was admitted to the facility on 7/6/2009 with diagnoses of Dementia, Depression, Cerebrovascular Accident, Hypertension, Chronic Kidney Disease, Diabetes, Cirrhosis, Parkinson's disease, Chronic Anemia, Hyperlipidemia and Hypertension. Resident #6's quarterly Minimum Data Set (MDS) assessment dated 10/28/2012 indicated the Resident # 6 had severe cognitive impairment, totally dependent on staff on bed mobility, transfer, locomotion, dressing and personal hygiene. Resident # 6's admissions Activity Assessment/ History dated 7/14/2009 documented Resident # 6's activity pursuit patterns were word games,	F 248	Resident #6 will continue to receive individualized ongoing activities per facility policy. An individual Geri chair was provided for resident # 6 by the DON on 1/14/2013 to assure resident ability to attend out of room activities. 100% of all residents to include resident #6 were reviewed on 1/22/2013 by the Activities Director to identify residents to include bed bound residents who require individualized 1:1 in room activities, out of room activities, or group activities according to the comprehensive assessment, interest, and their physical, mental, and psychosocial well-being and ensure that all residents identified have ongoing activities programming.	2-7-13 2-7-13

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

Temp DNHA 2-12-13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345326	A. BUILDING _____ B. WING _____	C 01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE NURSING AND REHABILITATION CENTER	711 SUSAN TART ROAD BOX 948 DUNN, NC 28334

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F 248	Continued From page 1 Bible study, devotions, Worship services, talking, cross word puzzle and spiritual/religious activities. Resident # 6's Care plan dated 1/10/2013 documented the resident's problem as at "risk for isolation and increased dependence on staff due to cognitive deficit." The interventions included "Arrange for activity aide to visit and encourage resident to or designate activity, Arrange 1 to1 contact with resident, Supervise resident in all activity areas, Offer activity program directed toward specific interests/ needs of resident." Review of the resident's activities attendance record revealed the facility staff provided the activities to Resident # 6 only two times for the month of November 2012. Further review of the attendance record revealed the staff provided activities only one time between 12/1/2012 and 12/8/2012. Attendance record also revealed beginning 12/28/2012 until 1/10/2013 the staff provided activities to the resident only three times. Observation of the resident's room on 1/10/2013 at 10:03 AM revealed the resident in her room with the radio playing. The resident was further observed at 11:26 AM, 1:30 PM and 3:00 PM lying in the bed with eyes open. Further observation of the resident revealed the resident not able to engage in meaningful conversation but appears to recognize someone's presence in the room. During an interview with the Activity Director (AD) on 1/10/2013 at 11:45 AM, she revealed Resident # 6 remained in her room most of the day and very rarely the staff took her out- of- the room for	F 248	The Activities Director and Activities Assistant were inserviced On 1/14/2013 by the Administrator regarding providing ongoing activities program per facility protocol for residents to include residents that require 1:1 in room activities, group activities, and bed bound residents with documentation per facility protocol in the activities programming log. The Activities Director and Activities Assistant will document weekly On all residents to include resident #6 who require 1:1 in room activities, group activities, and bed bound residents in the Activity programming log. The Administrator or QI Nurse will monitor the documentation of the activity programming log weekly for 4 weeks; bi-weekly for 4 weeks, and monthly for 3 months utilizing an Activity Monitoring Q.I. tool. Follow up by Administrator will occur as indicated upon identification of any potential concerns. The Q I Committee will review the Results of the Activity Monitoring QI Tool at the monthly QI meeting for identification of potential issues with follow up taken as deemed appropriate and to determine the continued need and frequency for monitoring.	2-7-13

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	345325	A. BUILDING _____ B. WING _____	C 01/10/2013

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F 248	Continued From page 2 out of the room activities. AD further stated she only provides 1: 1 in room activities to the resident two times in a month. AD also stated the resident would not be disruptive in any of the group activities but she (AD) just preferred to provide 1:1 in room activities two times in a month. During an interview on 1/10/2013 at 3:04 PM, the Administrator stated her expectation was for the Activity department to provide activities that would engage the resident both in room and outside her (resident's) room. The administrator further stated the resident currently did not have her own individual wheel chair but she (the Administrator) will make sure they provide one for the resident so that the resident can be able to attend out- of-room activities regularly.	F 248		

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	345325	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE NURSING AND REHABILITATION CENTER	711 SUSAN TART ROAD BOX 948 DUNN, NC 28334

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V-prot. construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Cornerstone Nursing & 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.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: soiled linen room door on 300 hall did not close and latch. 42 CFR 483.70(a)	K 029	Cornerstone Nursing & Rehabilitation Center's response to the Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cornerstone Nursing & Rehabilitation Center reserves the right to refute any of the deficiencies on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
		K029	300 hall soiled linen room was repaired by maintenance staff to close and latch. All doors were audited by maintenance staff for proper operation-closing and latching.	2-5-13
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		

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

Temp LNHA — 2-21-13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/05/2013

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K 067	Continued From page 1 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: both return and supply fusible links and dampers at main nurse station, have a white texture coating on the dampers and links. Also, their were no access doors to view duct detector tubes at units in main electrical room and mechanical room #1. 42 CFR 483.70(a)	K029	Maintenance staff will monitor all doors using a QI tool weekly for 4 weeks, monthly for 2 months. QI tool will be reviewed by QI Committee at the monthly meeting to determine the need and frequency for continued monitoring.	2-5-13
		K067	The white textured coating from return and supply fusible and fusible links at main nurses station was removed by maintenance staff. Access doors to view duct Detector tubes at units in Main electrical room and mechanical room #1 will be installed by outside contractor.	3-22-13
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: the deep fryer was located next to a prep serving area without the required splash guard in the dietary kitchen. Also, at time of survey there was not a emergency release handle inside freezer. 42 CFR 483.70(a)	K 069	A splash guard was installed In the dietary kitchen between prep serving area and deep fat fryer by maintenance staff. An emergency release was installed inside the walk in freezer by maintenance staff.	2-12-13

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	345325	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/05/2013

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	345325	A. BUILDING 02 - BUILDING 2 B. WING _____	02/05/2013

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K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: lifts were stored on corridors 300 and 500(plugged into outlet for charging). 42 CFR 483.70(a)	K 072	Patient lifts were reviewed from 300 and 500 patient corridors. Patient lifts will be stored for charging in designated rooms on each corridor. The storage of patient lifts will be monitored using a QI tool for 4 weeks then monthly for 2 months. The QI tool will be reviewed by QI Committee at the monthly meeting to determine the need and frequency for continued monitoring.	2-22-13

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

3-4-13

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03/04/2013 14:59 19108923690 CORNERSTONE NURSING PAGE 05/05