MAR 0 6 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. BUILDING ______ B. WING ______	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWN EAST HEALTH AND REHAB CEN	38 CARTERS ROAD GATESVILLE, NC 27938

(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 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT	F 273		

F 273 — 483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT (SS=D)

A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to complete a comprehensive admission Minimum Data Set (MDS) assessment by day 14 after admission for 1 (Resident #61) of 15 residents whose MDS was reviewed.

Findings include:

Resident #61 was admitted to the facility on 11/01/11 and was discharged on 11/18/12 to the hospital. Cumulative diagnoses included end stage renal disease, dysphagia, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, and coronary artery disease.

Review of the resident ' s medical record revealed no MDS had been completed since the new admission to the facility. Review of the hospital records revealed Resident #61 went home after the hospital stay, then was readmitted to the hospital on two separate occasions and subsequently was admitted back to the facility on 01/11/13.

Provider's Plan of Correction (F 273):

Disclaimer Statement

Down East Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction in order to comply with Federal and State survey and certification procedures and to demonstrate our continued provision of quality care to residents. The Plan of Correction is submitted as a written allegation of compliance with Medicare and Medicaid requirements for participation.

Down East Health and Rehabilitation response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission of any fact or that any deficiency is accurate.

Down East Health and Rehabilitation reserves the right to submit documentation or refute any of the stated deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal procedure and / or any other administrative or legal proceeding

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 3/4/13

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

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F 273	Continued From page 1 An interview, on 01/31/13 at 11:00 AM, was conducted with the facility ' s MDS consultant. She stated the facility had several nurses within the last year completing the assessments. She stated Resident #61 was due to be completed but it had not yet been done. Review of the schedule in the MDS office listed Resident #61 ' s assessment reference date (ARD) was 01/18/13 and to be completed by 01/25/13. The MDS consultant indicated that she and the new MDS nurse were in the process of bringing the MDS system for the facility up to date. An interview, on 02/04/13 at 11:15 AM, was conducted with the Assistant Director of Nursing (ADON). The ADON stated the expectation was for the MDS to be completed as scheduled.	F 273	F 273 1. The admission Minimum Data Set (MDS) assessment for Resident #61 was completed and submitted. 2. The MDS Coordinator has been re educated by the Regional Director of Clinical Services concerning the MDS assessment calendar representing all assessments that are due. An audit of all resident MDS assessments was performed and all required assessments have been completed and submitted. The calendar created for upcoming assessments was compared to the facility census to ensure that all upcoming MDS assessments would be scheduled appropriately for completion.	3/4/2013 3/4/2013
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	~~F 279~~	3. The MDS coordinator will print the Admission/Readmission report every week to compare to the calendar to ensure that all new admissions or readmissions are in the calendar showing the scheduled assessment due dates. Any variation of the report with the calendar will be immediately reported to the Executive Director and the Regional MDS leadership with the course of action taken to remedy the variance. This course of action will be written directly on the report to document the intervention. All of the printed reports will be kept for the next 12 months. The MDS coordinator will complete a monitoring tool to document the completion of the report process and turn it into the Executive Director weekly x 12 weeks and then monthly x 9 months.	3/4/2013

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F 279	Continued From page 2 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to develop a care plan for contractures for 1 of 3 residents (Resident #10) to address contracture care. The facility failed to develop a care plan to address the coordination of Hospice services for 1 of 1 residents (Resident #75) receiving Hospice care. Findings included: 1) Resident #10 was admitted to the facility on 10/29/12 with diagnoses that included Cerebral Vascular Accident (stroke), joint contractures, and decubitus ulcers. Review of the resident ' s Minimum Data Set (MDS), a 14 day assessment dated 11/12/12, revealed Resident #10 had a diagnosis of contractures and was dependent on staff for all care needs which included bed mobility, transfers, bathing, and toileting. The MDS indicated Resident #10 received Physical Therapy which had started on her admission to the facility. An Admission -Data Collection form dated 10/29/12 indicated Resident #10 had contractures in both legs. The resident ' s care plan dated 11/27/12 revealed no care plan had been developed to address the resident ' s contractures or	F273 ~~F 279~~	4. The MDS coordinator will report the results of the weekly comparison at the regularly scheduled monthly Performance Improvement committee for the next 12 months. 5. Allegation of Compliance for this plan is 3/4/2013.	3/4/13

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

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F 279	Continued From page 3 interventions to prevent a decline in range of motion A record review revealed an Admission Care Plan dated 10/29/12 which indicated Resident #10 had been identified for areas which included Cognitive Loss, Bladder and Bowel incontinence, Nutritional status, Activities of Daily Living, Pain, and Pressure Sores. Review of the resident ' s medical record revealed a Physician progress note dated 1/9/13 which indicated Resident #10 was very contracted and her extremities were stiff but there was movement in both upper and lower extremities. Review of a Physical Therapy evaluation dated 10/29/12 indicated Resident #10 was to receive skilled services which included Therapeutic Activities for seated and bed positioning for contracture management. A record review revealed a Physical Therapy Discharge Summary which indicated Physical Therapy sessions were completed on 11/19/12. The Discharge Summary revealed Resident #10 had reached her maximum potential and would continue with the Restorative Nursing Program. The summary revealed the Restorative Nursing staff was instructed in proper techniques for prolonged stretches and positioning for Resident #10. A Restorative Tracking Form which indicated Resident #10 received Restorative Nursing in November 2012 and the program included Passive Range of Motion for six times a week for	F 279	1. The care plans for resident #10 has been updated to include the all of the care issues pertinent to the resident, including the plan of care for contractures. The hospice provider has provided a care plan for Resident #75 that is coordinated with the resident's facility care plan. 2. All Care Plans have been reviewed and all care issues pertinent to each resident are represented in the individual care plan. The Administrative nurses have been re educated by the Regional Director of Clinical Services that ongoing the care plans will be brought into the morning meeting and will be updated with any new orders and/or issues that are a part of the 24 hour report. All Nursing staff will be re educated on updating the 24hr report prior to taking assignment on their next scheduled shift. The care plans will also be reviewed for appropriate updates during the weekly meetings that are held to review falls, weights, wounds, and restraints. 3. The Director of Clinical Services or Unit Manager will complete a performance improvement tool showing the review and updating of care plans during the morning meeting. This audit tool will be done 5x a week or 4 weeks, 3x week for 4 weeks, weekly x4 weeks, and monthly x 9 months. These audit tools will be turned in to the Executive Director as they are completed.	3/4/13 3/4/13 3/4/13

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F 279	Continued From page 4 a total of four weeks. The goal of the Restorative Program for Resident #10 was to reduce contractures to all extremities. A Restorative Nursing progress note dated 11/22/12 for Resident #10 indicated Resident #10 was very contracted and PROM exercises were done as tolerated. During an interview on 1/3/1/13 at 2:45 PM with Restorative Nurses Aide (RNA) #1 indicated Resident #10 was on PT caseload upon admission and then was discharged to restorative nursing. The RNA indicated Resident #10 had received restorative nursing for several weeks for PROM and positioning was discharged on 12/14/12 to nursing. The RNA indicated Resident #10 was re-admitted to restorative on 1/11/13 for positioning to reduce pressure and prevent skin breakdowns. An interview was conducted on 1/31/13 at 3:00 PM with Nursing Assistant (NA) #2 who was caring for resident, NA #2 indicated the resident was dependent for staff for care, but was unsure if she needed to do PROM with Resident #10. An interview was conducted on 1/31/13 at 5:20 PM with the MDS Consultant. The Consultant reported Resident #10 had been identified for contractures, but did not have a care plan to address goals and interventions. The R MDS indicated Resident #10 should have had a care plan regarding contractures. During an interview on 1/31/13 at 6:15 PM with the Administrator and indicated she expected care plans to be completed accurately for all	F 279	4. The Director of Clinical Services or Unit Manager will report the findings of these performance improvement tools to the Performance Improvement Committee at the regularly scheduled monthly meeting x12 months for review and consultation about the results. 5. The Allegation of Compliance for this plan is 3/4/2013.	3/4/13

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F 279	Continued From page 5 residents. 2) Resident # 75 was admitted to the facility on 11/21/12 following a hospital stay and was admitted to the facility for Hospice care on 11/21/12 for a terminal diagnosis which included metastatic cancer of the thoracic spine with cord compression and pathological fracture of the thoracic spine (T-10). Review of the resident ' s MDS, admission assessment dated 11/28/12, revealed Resident #75 was cognitively intact and able to make decisions. The MDS indicated Resident #75 required extensive assistance to total dependency for his activities of daily living which included bathing, toileting, hygiene, and transfers. The resident was able to eat independently with set up assistance. The assessment revealed Resident #75 was admitted to the facility with a Stage 4 pressure ulcer and had interventions which included a pressure reducing mattress and treatments for the ulcer. A record review revealed a care plan dated 11/21/12 that included self-care deficits in daily living, and pain. There was no care plan to address coordination of care with Hospice. On 1/31/13 at 3:40 PM, an interview with Nurse # 3 revealed the Hospice staff did not document in the facility records and generally took their documentation with them. The staff nurses usually tried to speak with the Hospice nurse when she was here. On 1/31/13 at 5:00 PM an interview with the Hospice SW indicated she visited Resident #75	F 279		

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F 279	Continued From page 6 weekly and as needed. The Hospice SW revealed she did not document in the facility records and she took all of her documentation with her. The Hospice SW indicated she did not always communicate her visits with the facility SW and/or staff. An interview was conducted with the facility SW and Administrator on 1/31/13 at 5:25 PM and revealed they expected a Hospice care plan to address coordination of care for Resident #75 should have been developed.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to obtain a stool culture for 1 of 1 resident (Resident 15) reviewed for completion of physician ' s laboratory orders. Resident #15 was admitted to the facility with cumulative diagnoses of a history of colonic resection, history of urinary tract infection, and dementia. The resident had been on a course of Augmentin (an antibiotic) for a diagnosis of pneumonia. Review of the medication administration record revealed the resident finished the course of therapy on 01/19/13.	F 281		

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F 281	Continued From page 7 Lexicomp ' s Geriatric Dosage Handbook, 17th edition, notes Augmentin (amoxicillin and Clavulanate potassium) as an antibiotic used in the treatment of community acquired pneumonia in adults. Diarrhea for 1 to 10% of patients was listed under adverse reaction of Augmentin. Review of the resident ' s medical records revealed a physician order written on 01/21/13 at 3:33 PM for Clostridium difficile " (C-diff, O&P) (ova and parasite) stool culture (obtain) " . A diagnosis was indicated as diarrhea. Clostridium difficile infections often occur after exposure to antibiotics when the normal flora of the intestinal tract is altered and the patient can experience significant diarrhea which could lead to dehydration. Ova and parasite testing rules out other types of infection which can also cause diarrhea. Record review of the physician ' s progress notes revealed the attending physician had seen the resident on 01/23/13 for complaints of diarrhea. He noted that the diarrhea had subsided but did not discontinue the order to get a stool culture. Review of the laboratory records indicated the culture results were not on the record. During an interview with the Assistant Director of Nursing (ADON) on 01/29/13 at 2 PM she stated she would attempt to find the culture results. Interview the ADON on 01/30/13 at 3 PM revealed that the culture results sent to the facility on 01/24/13 by fax stated, " No clean vial stool received " indicating that the culture was not completed. The assistant director of nursing stated her expectation would be that all order	F 281	1. The order for a stool culture for resident #15 was canceled because the resident did not have any further loose stools. The lab has been contacted and the facility is now stocked with all necessary supplies to collect stool samples as ordered. 2. All Licensed Nurses currently in the facility were re educated as to the process of labs that are ordered. All other Licensed Nurses will be re educated concerning the lab process before accepting an assignment for their next shift. The lab sheet will be fully completed to show the resident name, the date of the order, the labs that are ordered, the date the lab was obtained, who obtained the sample, the date the results were received back to the facility, the date the MD was notified of the results, and the any new ordered repeat of the lab by the MD. The Administrative Nurses and weekend RN Supervisors will review the lab book dailyto ensure that the lab sheet is filled out completely to show the entire process was followed.	3/4/13 3/4/13

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F 281	Continued From page 8 cultures and lab draws order by a physician would be completed and if it could not be completed, the physician would be notified.	F 281	3. The Director of Clinical Services, Unit Manager, or the RN Supervisor will review the lab book and complete the QI monitoring tool daily x 2 weeks, then in every Morning Meeting the lab book will be reviewed and the QI Monitoring tool will be filled out weekly to document the daily verification. 4. The Director of Clinical Services or Unit Manager will present the written report of this process monthly x12 months to the Performance Improvement Committee for review and consultation about the results. 5. The Allegation of Compliance for this plan is 3/4/2013	3/4/13 3/4/13
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide services to prevent a decrease in range of motion for 1 of 3 (Resident #59) residents reviewed with diminished range of motion. Resident #59 was readmitted to the facility on 6/21/12 with diagnoses to include quadriplegia. Observation of the resident on 1/31/13 at 10:30 AM revealed the resident was wearing padded boots on both lower extremities with a pressure relieving device between the knees. Both lower extremities were bent at the knees. Observation of the resident during an interview of 1/31/13 at 2:10 PM revealed the resident was unable to straighten his legs completely by hand as he stated he had done in the past when he lived outside the facility. The resident stated staff did not do any stretching or range of motion	F 318		

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F 318	Continued From page 9 exercises with his lower legs. During an interview with the resident, the resident reported he completed 270 repetitions of bilateral upper arm exercises daily to build his upper arm strength. The resident was able to demonstrate his ability to raise his arms over his head with difficulty and straighten his arms. Review of the resident ' s care plan of 1/22/13 revealed no problems identified for contractures or decreased range of motion. The Nursing Assistant ' s care plan guide had no written instructions for range of motion exercises. Review of the resident ' s annual Minimum Data Set (MDS) of 8/1/12 revealed the resident had impairment of both sides of his upper and lower extremities. The resident had no received services of physical or occupational therapy, but had received 7 days of Restorative Nursing for range of motion. Review of the quarterly MDS assessments of 10/17/12 and 1/6/13 indicated the resident received no Restorative Nursing services. The resident was assessed as cognitively intact. Physician ' s orders for January 2013 revealed no orders for therapy services or restorative nursing. Review of the facility ' s " Nurse Tech Information Kardex " (nursing assistant care guide) had no instructions for range of motion exercises. During an interview with Nursing Assistant (NA) #1 and NA #2 on 1/31/13 at 2:20 PM, the NAs reported they provided range of motion exercises with the resident's lower extremities when providing his bath and repositioned the lower legs when he was repositioned in bed.	F 318	1. A program for range of motion services have begun for Resident #59 due to diminished range of motion. These services will remain in place as the resident tolerates. 2. All residents will be re assessed to determine need for a program of range of motion due to a diminished range of motion. Any resident identified as having diminished range of motion will be assessed by therapy for appropriate program development to improve range of motion. The restorative nurse and aide have been re educated to identify residents with diminished range of motion and request a therapy screening. 3. The Director of Clinical Services or Unit Manager will review each new admission/re admission for need for therapy screening for diminished range of motion. All appropriate admissions will be screened by therapy and placed on a range of motion program. The Director of Clinical Services or Unit Manager will make walking rounds with the restorative aid on a weekly basis to assess the residents who are on a range of motion program and review the program for appropriateness. These findings will be documented on a performance improvement tool and turned in to the Executive Director weekly x 8 weeks and then monthly 10 months.	3/4/13 3/4/13 3/4/13

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F 318	Continued From page 10 An interview was conducted with the Corporate MDS Consultant on 1/31/13 at 3:38 PM, The Consultant stated the MDS nurse was expected to discuss the limitation in range of motion of the resident in the morning Medicare meeting with Therapy present to decide on a course of action to address prevention of further contractures The MDS nurse who completed the resident ' s assessments was not available for interview during the survey. An interview was conducted with the Administrator and Corporate Nurse Consultant on 1/31/13 6:02 PM. The consultant stated the expectation that any need assessed on admission, the resident should have received the needed services. The Director of Nursing was not available for interview during the survey.	F 318	4. The Director of Clinical Services will present the performance improvement tools to the scheduled monthly performance improvement committee for review and consultation about the results. 5. The allegation of compliance for this plan is 3/4/2013	3/4/13
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure monitoring and interventions for outside activities for 1 (Resident # 24) of 1 resident with severe cognitive impairment who had been observed in the facility	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 parking lot. Findings include: Resident #24 was admitted to the facility on 03/01/06 and readmitted on 10/18/12. Cumulative diagnoses included Alzheimer ' s disease, dementia, glaucoma, and schizophrenia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/30/12, revealed Resident #24 was assessed to have severe cognitive impairment, required extensive assistance with Activities of Daily Living (ADL ' s) with the exception of locomotion. For locomotion in and out of the resident ' s room and hallways at the facility, the assessment indicated the resident was independent and used a wheelchair. . Review of the care plan identified a problem area, which began 11/07/11 and was last updated on 09/2012, listed as " Thought process altered/delirium-periods of disordered thinking/awareness secondary to Alzheimer ' s disease. " Two of the approaches listed on the care plan were to monitor for changes in behavior, mood, orientation, alertness, communication as compared to base line cognitive abilities and to observe for changes in behavior, cognition, alertness, communication, speech, anxiety, ADL ' s, hearing and vision. Another problem area identified on the care plan and read as: " Resident is frequently incontinent of urine. " One of the approaches listed was to observe the resident for acute behavioral changes that may indicate a UTI. Review of Resident #24 ' s nurse ' s notes, dated 09/05/12 for the 7-3 shift, revealed documentation	F 323	1. Resident #24 has been reassessed to determine the level of monitoring and interventions necessary for outside activities. He will be supervised according to the assessment. 2. All residents have been re assessed to determine the level of monitoring and interventions necessary for outside activities. All licensed nursing staff has been re educated by the Director of Clinical Services or Unit Manager concerning the use of the Interact II assessment tool Physician Communication and Progress Note for New Symptoms, Signs, and other Changes in Condition (SBAR) and the need to include on the 24hr report any resident who has a change of behavior related to outside activities. This re education will include the identification process which will be documented on the SBAR: and the intervention to provide safety which will be documented on the 24 hr report, in the nurses notes, on the care plan and on the CNA cardex. There will also be re education for notification of the RN on call concerning the change in behavior to ensure that all interventions are appropriate.	3/4/13 3/4/13

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. BUILDING ______ B. WING ______	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWN EAST HEALTH AND REHAB CEN	38 CARTERS ROAD GATESVILLE, NC 27938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12 that read in part: " Resident up in wheelchair propelling self around facility at the present. No noted distress or adverse reactions noted. Continues on ABT (antibiotic). Resident confused, going in other resident ' s rooms. Resident was in parking lot outside of building. Resident brought back into facility and explained of the danger d/t (due/to) altered mental status, resident should remain inside. Will continue to monitor. " A phone interview, on 02/04/13 11:45 AM, was conducted with Nurse #1, who had taken care of the resident on 09/05/12 during the 7-3 shift. Nurse #1 reviewed the nurse ' s notes and indicated the resident had a urinary tract infection (UTI) and usually is more confused at that time. She continued that when the resident had a UTI, the staff keep him closer to the nurse ' s station or have him stay more in his room. She remarked the resident was able to go out on the facility porch independently, usually sat at the end of the walk way, but on this date saw him out in the parking lot and proceeded to go out and brought him back into the facility. The Nurse stated the resident was not in the center of the parking lot, but where the cars parked at the front of the building. She indicated she was not aware of any previous time he had been in the parking lot. She also confirmed it was not usual behavior for him to go in and out of other resident ' s room but he did have a UTI. The Nurse stated that she would have provided this information to the oncoming nurse and the oncoming nurse would provide it to the next shift as well so the nurses would be aware of the incident. Review of Resident #24 ' s nurse ' s notes, dated	F 323	3. The Director of Clinical Services or Unit Manager will review the 24 hr report during each morning meeting and will review the SBAR, the nurses' notes, the care plan, and the CNA cardex. This review will be documented on a performance improvement tool that will be completed in the morning meeting daily x 4 weeks, weekly x4 weeks, and then monthly x 10 months. 4. The Director of Clinical Services will report the findings of these reviews at the scheduled monthly Performance Improvement Committee for review and consultation about the results. 5. The allegation of compliance for this plan is 3/4/2013	3/4/13 3/4/13

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F 323	Continued From page 13 09/10/12 at 10:30 PM, revealed documentation that read in part: " Pt (patient) had a BM (bowel movement) in his w/c (wheelchair) and roommate ' s w/c. Denies pain. Contiuues to talk to self about random events. Will continue to monitor. " Review of Resident #24 ' s nurse ' s notes, dated 09/10/12 at 11:00 PM and identified as a late entry, revealed documentation that read in part: " Pt was observed out in parking lot. Wheeling in the middle of parking lot with traffic incoming and outgoing. Pt brought back into building. No other behaviors noted than having BM ' s in his w/c and roommates ' s w/c. " A phone interview, on 01/31/13 at 5:06 PM, was conducted with Nurse #2, who had taken care of Resident #24 on the evening shift on 09/10/12. The Nurse stated early in the evening the resident was observed to be out in the area off of end of the breeze way where he usually sat and in the area of the parking lot where cars parked. She indicated he did go outside by himself and he usually sat at the end of the walkway, but on this date had gone out into the parking lot. The Nurse stated she had gone out to check on him and found him in the parking lot and brought him back into the building. She remarked she could not remember much more about the incident of that evening. She went onto state that when the resident does get a UTI he is more confused. When asked if she was aware of the incident in the parking lot on 09/05/12, she indicated she was not. A second phone interview, on 02/10/12 at 6:30 AM, was conducted with Nurse #2. She reviewed the nurse ' s notes for 09/10/12 and indicated that	F 323		

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F 323	Continued From page 14	F 323		

the resident was just off the walkway into the parking lot area where the cars would park, not in the middle of the parking lot as the nursing notes described. She stated in the notes she was trying to describe the event so that readers would understand he was in the parking lot. The Nurse stated he was being treated for a UTI and the only other behavior he had was having BM ' s in his w/c and his roommate ' s w/c. She confirmed it was not usual behavior for the resident to have BM ' s in his w/c or his roommate ' s w/c. The Nurse stated she checks on him when he goes outside but was not aware of the length of time he was off the breeze way into the parking lot. The Nurse remarked when she brought the resident back into the facility she had placed a flag on his chair to alert the staff where the resident was when he was out of his room. She indicated she would report to the nurse on the next shift about the incident and put it on the 24 hour (hr) report. She remarked she could not remember if she had put it on the 24 hr report.

On 01/30/13 at 11:00 AM, a request was made to the Administrator for information in the nursing notes regarding Resident #24 being in the parking lot.

On 01/30/13 at 11:10 AM, the Administrator shared there was no information regarding the incidents for review. She continued that he was brought back into the building by staff and a flag was placed on his chair so that he whereabouts could be monitored by the staff.

A conference, on 01/31/13 at 7:15 PM, was conducted with the Administrator, the facility Nurse Consultant (NC), and the facility Human

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F 323	Continued From page 15 Resource (HR) consultant. When asked about the expectations regarding the incidents of 09/05/12 and 09/10/12 when the resident was observed out in the parking lot, the Nurse Consultant stated the nurses needed to bring the information to administration ' s attention but that they had not received the information in order to put all the pieces together. The NC indicated the administrator would need to look at the information and do a follow-up. The HR consultant remarked the nurses would require further education regarding reporting process for issues to be placed on the 24 hr report so that information was available to administration and staff.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		

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F 329	Continued From page 16 drugs.	F 329		
	This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to hold a dose of Epogen (epoetin alfa) based on laboratory results, physician ' s order and manufacturer ' s recommendation for 1 of 10 (Resident # 22) residents reviewed for unnecessary medications Findings include Resident # 22 was admitted to the facility on 11/08/11 with cumulative diagnoses of chronic kidney disease, weakness, osteoarthritis and anemia of chronic kidney disease. Record review of the physician ' s order sheet for January 2013 revealed an order for Procrit MDV (multi dose vial) 20, U/ml (units per milliliter) Inject one milliliter (20,000 U) subcutaneously every 2 weeks *Hold if HGB (hemoglobin) >10, (10 Gm/dL grams per deciliter) for anemia. The order was written on 10/17/12. Lexicomp ' s Geriatric Dosage Handbook, 17th edition in a monograph titled Epoetin Alfa stated that Epogen is a colony stimulating factor, used in the treatment of anemia of chronic kidney disease to produce more red blood cells. Record review of the laboratory records for Resident #22 revealed a hemoglobin/hematocrit was drawn on 01/12/13 and was reported to the		1. The Medical Director was made aware of the issue with the Epogen and lab results and the medical concerns associated with this incident were resolved for Resident #22. 2. There was a complete audit performed by Omnicare Pharmacy nurses to compare the MD orders with the Medicine Administration Record, the Treatment Administration Record, and the contents of the medication carts. All medications that have been ordered which require a review of required laboratory results prior to administration of the medication were identified. A list of these medications has been created. All licensed nursing staff has been re educated as the necessity of verifying lab results prior to giving medication that has been ordered to be held dependant on the results.	3/4/13 3/4/13

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F 329	Continued From page 17 facility on 01/12/13 at 5:26 PM by the lab. The laboratory results documented the resident had hemoglobin of 10.3. Record review of the MAR (medication administration record for January 2013) revealed the Epogen was given on the 14th. The staff who gave the medication was not available for interview, but the Assistant Director of Nursing (ADON) confirmed that a signature or initial on the MAR would indicate the dose had been given. An interview with the ADON on 01/30/13 at 2:30 PM revealed her expectation was that a medication was held as directed by the physician ' s order. The ADON stated that the staff who gave the medication checked the chart for laboratory results prior to administering the medication since the order had specific instructions for holding a dose.	F 329	3. The Director of Clinical Services or Unit Manager will utilize the list of medications that have been ordered with a review of required laboratory results before giving the medication to verify compliance in the documentation in the Medicine Administration Record 5x a week x 4 weeks, weekly x 4 weeks, then monthly x 10 months. The Director of Clinical Services or Unit Manager will also check the new orders during each morning meeting to identify any new medications that have been ordered with a review of required laboratory results before giving the medication and add them to the list for review 5x a week x 4weeks, weekly x 4 weeks, and then monthly x 10 months. These checks will be documented on a performance improvement tool. 4. The Director of Clinical Services or Unit Manager will present the performance improvement tools to the monthly scheduled Performance Improvement Committee for review and consultation about the results. 5. The allegation of compliance for this plan is 3/4/2013	3/4/13 3/4/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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RECEIVED FEB 27 2013 CONSTRUCTION SECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWN EAST HEALTH AND REHAB CEN	35 CARTERS ROAD GATESVILLE, NC 27938

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type (V 111) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The Plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: A. Based on observation on 02/15/2013 there were unsecured 02 cylinders in the 02 storage room. 42 CFR 483.70 (a)	K 076	K 076 1. Oxygen storage room located on B-Hall O2 cylinders are secured in the appropriate O2 rack. 2. Licensed Nurses, Maintenance Director, Customer Care Liaison/Mock Surveyors have been re-educated on placing O2 tanks in the appropriate racks. Racks for full and empty Cylinders have been identified. Mock Surveyor /CCL will monitor O2 room for O2 to ensure that cylinders are secured in the appropriate rack Monday-Friday. The CCL will monitor O2 room to ensure that cylinders are secured in appropriate rack on the weekends. 3. ADMIN/Maintenance Director of Designee will conduct Quality Improvement (QI) monitoring of this standard 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x weekly for 4 weeks, then 1 x monthly for 9 months.	3/15/13 3/15/13 3/15/13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tammy Q. Harvey TITLE: Administrator (X6) DATE: 2/27/2013

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

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	345406	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWN EAST HEALTH AND REHAB CEN	38 CARTERS ROAD GATESVILLE, NC 27938

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K 147	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 02//15/2013 the GFCI receptacle in room C-119 failed to operate. 42 CFR 483.70 (a)	K 147	K 076 4. ADMIN/Maintenance Director/Designee will report results of the Quality Improvement monitoring to the Risk Management/Quality Improvement committee monthly x 12 months for continued compliance and/or revision. 5. Completion date 3/15/2013	3/15/13

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K 147	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 02//15/2013 the GFCI receptacle in room C-119 failed to operate. 42 CFR 483.70 (a)	K 147	K 147 1. The GFCI receptacle in room C-119 has been replaced, and is operating properly.	2/16/13
			2. The Maintenance Director has completed Quality Assurance rounds to assure that all GFCI receptacles are operating properly through out the facility. Maintenance Director was re-educated by the Executive Director on monitoring for functioning and replacing inoperable GFCI receptacles when appropriate.	3/15/13
			3. ADMIN/Maintenance Director will conduct Quality Improvement monitoring of this standard 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months.	3/15/13
			4. ADMIN/Maintenance Director will report results of QI monitoring to the Risk Management/Quality Management Committee monthly for 12 months.	3/15/13
			5. Completion date 3/15/2013	