APR 3 0 2013

PRINTED: 04/17/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT (STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED			
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	OVIDER OK SUPPLIER NDS NURSING & REHAE	BILITATION CENTER	STR 44			
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	consult with the resid known, notify the resi or an interested famil accident involving the injury and has the pointervention; a signific physical, mental, or p deterioration in health status in either life the clinical complications significantly (i.e., a ne existing form of treatment); or a decision or an interestment; or a decision or an interestment or an interest or an interes	lately inform the resident; ent's physician; and if dent's legal representative y member when there is an e resident which results in tential for requiring physician cant change in the resident's esychosocial status (i.e., a n, mental, or psychosocial reatening conditions or); a need to after treatment eed to discontinue an	F 157	Statement of Deficiency and propo- plan of correction to the extent t summary of findings is factually and in order to maintain complian- applicable rules and the provis quality care to residents. The	of the sees the hat the correct ce with ion of blan of written nent of oes not ion by illitation right to e stated appeals	
	and, if known, the resor interested family no change in room or rospecified in §483.15 resident rights under regulations as specifithis section. The facility must receive address and phologal representative of this REQUIREMENT by: Based on staff, phys	promptly notify the resident sident's legal representative nember when there is a ommate assignment as (a)(2); or a change in Federal or State law or ied in paragraph (b)(1) of ord and periodically update ne number of the resident's or interested family member. It is not met as evidenced sician interviews and recordically to notify the physician of		Resident #1 expired in the facility on 04/01/2013. Review of the resident record indicates the resident was his own responsible party and requested that his family not be notified of his change in condition and he declined offers of hospitalization. The record indicated the physician was notified of the resident's change in condition and his desire not to be hospitalized.		
		CINATI		nesite not to be nosbitalized.		(XQ) DATE

Any deficiency statement ending with an extense (*) 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.

PRINTED: 04/17/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 345481 B. WNG 04/05/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE WOODLANDS NURSING & REHABILITATION CENTER FAYETTEVILLE, NC 28301 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) The physician indicated to F 157 | Continued From page 1 F 157 continue to monitor the resident continued respiratory distress, that the resident's condition worsened and the resident became although the option of unresponsive in 1 of 3 sampled residents with a hospitalization was declined by change in condition (Resident #1). the resident. Immediate Jeopardy bogan on 4/1/13 and was The Director of Nursing was identified on 4/5/13 at 1:00 PM. Immediate terminated by the administrator . Jeopardy was removed on 4/5/13 at 6:30 PM when the facility provided a credible altogation of on 04/05/2013. compliance. The facility will remain out of compliance at a scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate Jeopardy). The facility was in the process of full implementation and monitoring their corrective action. The facility has determined that all residents have the potential Findings included: to be affected but currently, after Resident #1 was admitted to the facility on review of 24 hour shift reports, 3/18/13 with diagnoses of End Stage Chronic 4-4-13 Obstructive Pulmonary Disease and Emphysema. there is no evidence of any deficient physician or resident The admission Minimum Data Set (MDS) dated representative communication 3/25/13 indicated that resident #1 had no short term or long torm memory problems and no on 04/04/2013. documented behavioral problems. He was coded as cognitively intact and the MDS indicated that he depended extensively on staff for all of his activities of daily living. Resident #1 was not All licensed nursing staff have coded as having a prognosis of less than 6 been assigned on-line learning

nasat cannula.

months life expectancy. Resident #1 required

A review of resident #1's medical record indicated that he was his own responsible party and signed

continuous oxygen at 4 liters/minute using a

his admission paperwork to include the Code

Status Resuscitation Request/Order form

04/05/2013.

course "Effective Communication"

which includes the SBAR tool for communication to the physician,

All licensed nursing staff will be :

4-19-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	VAIE	
F 157	indicating he would like event of a cardiac or a document was dated. A review of the Medic (MAR) indicated that resident # 1's oxygen liters/minute of oxygen. A review of the medic routine vital signs wor PM. Resident #1's vit follows: blood pressurespirations 20. A nursing note writter resident #1 was obsestiumped over in his can oxygen saturation did not indicate if his time he was found. Heatment and his oxy 95% on 4 liters/minucannula. Resident #1 follows: blood pressurespiration 48 (elevat The nursing note indigo to hospital for evaluation in the direct of the sident #1 notified. A review of the Situat Assessment Recommedated 4/1/13 indicated resident #1 was cyan	ke to be resuscitated in the respiratory arrest. This 3/18/13. cation Administration Record at 10:00AM on 4/1/13, a saturation was 90% on 4 on using a nasal cannula. cal record indicated that re taken on 4/1/13 at 12:20 tal signs at that time were as the 132/94, pulse 110, in by nurse #1 indicated that prived at or around 2:30 PM chair. He was clammy with of 81%. The nursing note oxygen was in use at the le was given a breathing year saturation increased to tes of oxygen using a nasal is vital signs were as the 82/60 (low), pulse 78, and) and temperature 97.9 F. icated resident #1 refused to luation and he did not want the nursing note also pector of nursing (DON) and the physician was stional Background nendation (SBAR) form dinurse #1 reported that notic (blue or purple)	L.	157	in-serviced by the DON or appropriate designee regarding the following: F Tag 157: Notification of Change Facility policy on Change in Resident Status which includes notification of physician, Validation Checklist for Notificat of Changes, and Documentation of Notification, on 04/19/2013 Any licensed staff member who has not been trained as of 04/19/2013 will not be allowed report for duty until training is complete. This information will included as additional training ir licensed nursing orientation and annual re-orientation. All CNAs and Med Aides were in-serviced by the DON or appropriate designee on Notification of change in resident condition 04/19/2013. Any CNA or Med Aide that has not been trained a of 04/19/2013 will not be allowed to report for duty until training it complete.	ge tion to be n d	4-19-13	
		iotic (blue or purple kin), short of breath and			complete.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 157	instructed the staff to monitor his vital sign DON was aware of ti 2:30 PM. The medication adm dated 4/1/13, indicat #1 was not responsimedications. The M/aide (MA) #1 notified condition. A review of resident no ongoing assossm PM until approximate medical services (EM no evidence of any cresident #1's respirationary changes. According to the EM approximately 6:15 I	form indicated the physician observe resident #1 and s. This form indicated the he physician's directive at inistration record (MAR) ed that at 4:34 PM, resident we enough to take his AR noted that the medication in nurse #2 of his change of #1's medical record indicated tent from approximately 2:30 ely 6:15 PM when emergency MS) was notified. There was engoing assessment of	F		24 hour nursing reports will be reviewed by the supervising or charge nurse each shift for identification of proper notification of physician and resident representative as need and per facility policy. Any discrepancies in notification will be corrected by the supervising charge nurse reviewing the 24 if report, 04/05/2013 and ongoin Validation Checklist will be utilize by the nurse in charge of the resident with a change in conditrequiring physician and resident representative for a period of 4 vibeginning 04/05/2013. F-157 Notification of Change and	I, or nour · g. zed tion t veeks,	4-19-13 ongoing ongoing
	was in progress by found without a puls unresponsive. His since the second without a puls and the second was provided in an interview on 4/1/13 she asked the DON because she wanted refused to go to hos DON stated the hos resident #1 that the	kin was cold to the touch. shounced dead at 6:45 PM. 4/13 at 12:11 PM, nurse #1 8 at approximately 2:30 PM			will be conducted by the DON, or appropriate designee weekly x 4 monthly x 2 months, quarterly x 3 quarters, and as needed. 24 hour reports will be review by the facility administrative team 5 x per week x 4 weeks compliance with plan as state above and Validation of Notification forms during Mo	weeks, 3 ved for	

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SU			.1	STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301		[<i>Q41</i> -	9012013
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report with resident #1 him for chastatus. Nur #2 who was the nursing notified. Nurse #2 in sinstruction full code as DON and protocolor full code as protocolor full code as sistent (is approximate the bed. So receiving a removed the breathe. No place. Not resident #1 an interestated that #1. She sist treatment if room. She was wet we resident #1	thated that the physic and monity anges in hi se #1 stat se #1 stat the 3-11 g station w urse #1 stat the shift one. Nurse and she did chysician ' f she spec dic or a ful the stated t I was four view on 4/- NA) #1 stated to reathin that mask a the y2:45 f She said he at breathin that mask a the y1 told if 's room and she rep the with res view on 4/- i nurse #1 aid he was in progres to said he view on 4/- i nurse #1 aid he was in progres to said he view on 4/- i nurse #1 aid he was the y1	she completed a SBAR clan instructions to observe for his vital signs and notify is respiratory or mental ed that the DON and nurse shift nurse, were present at then the physician was sted she also reported to change report the physician "#1 stated resident #1 was a not feel comfortable with the sinstruction. Nurse #1 could difficulty stated that resident #1 code but that she thought the SBAR form indicated that difficulty stated that resident #1 in a had a mask on his face is treatment. She stated he and stated he couldn't nim to keep treatment in she did not go back into because her shift ended at corted off to the NA #2 who ident #1 on 2nd shift. 4/13 at 2:00 PM, the DON asked her to look at resident in the bed with a breathing is when she entered the was in a hospital gown and he not that this was unusual for ted she instructed nurse #1 to r an impaction. She	f	157	Meeting. Non-compliance will discussed during this meeting wimmediate notifications made a needed and the nurse (s) respo for any non-compliance re-in-se and disciplined by the DON or appropriate designee. The revithe 24 hour report will be contiwith a minimum of weekly reviews, x 2 months, followed by quarterly: quarters, and as needed, ongoin Review of the Validation report be reviewed 5 days per week by Facility Administrative Staff during Meeting x 1 week, followed quarterly x 3 quarters, and as needed, ongoing. Review of Notification of Change Audits will be reviewed by the facility Administrative Staff during Morning Meeting weekly x 4 weeks, monthly x 2 months quarterly x 3 quarters, and as needed, ongoing.	vith as as asible erviced ew of aued ews as will y the ang owed by	4-19-13 organg organg

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

IDENTIFICATION NUMBER:

345481

PRINTED: 04/17/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED С 04/05/2013

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

WOODLANDS NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301

(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)	(XS) COMPLETION :

A. BUILDING

F 157 Continued From page 5

instructed nurse #1 to administer a suppository, The DON stated she onsured resident #1's head of his bod was up and his oxygen was in place. The DON stated nurse #1 called the physician around the time of shift change. The DON stated awareness of resident #1's code status. The DON stated she did not actually assess resident #1 but rather was present during the impaction removal by nurse #1. The DON stated awareness of resident #1's vital signs. She stated she stayed in the room while he was cleaned up and ensured his oxygen was in place and the head of his bed was up. The DON stated she was at the nursing station when nurse #1 notified the physician. She could not recall if nurse #1 made the physician aware of resident #1 full code status, 'The DON' stated she not make contact with floor staff again prior to leaving work that day around 6:00 PM.

In an interview on 4/4/13 at 3:00 PM, modication aide (MA) #2 stated she went to see resident #1 at the beginning of her shift. She stated resident #1 was thrashing about in the bed and unable to respond to her questions. She stated his oxygen was in place at the time. MA #2 stated she returned to the nursing station and stated she thought resident #1 was dying, MA #2 stated the DON, nurse #1 and nurse #2 were standing at the nursing station and no nurse went to the room with her to see resident #1, MA #2 asked nurse #1 if they were sending him to the hospital. Nurse #1 told her that the DON told her not to send him out. Nurse #1 stated the physician told them to monitor for any further decline in his condition and call him back, MA #2 stated that at 4:34 PM, she tried to give resident #1's his scheduled medication but he was not responsive enough to take his medicino. She stated she told nurse #2

This plan and its outcomes will be reviewed by the QA committee ... during the monthly QA meeting. Any deviations of the plan will be examined using a RCA approach to the Issue and amendments to the plan as needed. This review, outcomes, recommendations, and monitoring will be included in the facility QA meeting minutes. Any changes to the plan above will be documented in the QA meeting minutes, appropriate staff re-inserviced to changes in the plan. Any changes made to the above plan will require the monitoring of such changes to begin at the initial review schedule of 5 days/week x 1 week; weekly x 3 weeks; monthly x 2 months, quarterly x 3 quarters, and as needed.

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1		ONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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F 157	stated nurse #2 did resident #1 to her haround 6:15 PM, si and she responded the MDS nurse init. On 4/5/13 at 11:13 NA #2 stated that at #1 told her that resall day and she ne NA #2 stated she wital signs or what nurse #2. NA #2 si eye on him" by nur to room to see resappeared to be in distress as uncomunable able to resign gasping for breath head was off of the back on pillow. NA was in place. NA # to check on reside #2 stated at dinner and got to his room worse. She stated was not breathing she went to the do The MDS nurse a and started CPR. stated that nurse and nurse #2 call	change in condition. MA #2 I not go to the room to assess knowledge. MA #2 stated that he heard a code announced it to resident #1's room to find liating CPR. 2 AM, in a telephone interview, on 4/1/13 around 3:00 PM, NA sident #1 had not been himself edded to keep an eye on him. was not instructed to get any conditions she was to notify lated she was told to "keep an rise #2. NA #2 stated she went ident #1 and noted that he distress. She described fortable, moving around in bed, ponds to her questions and . NA #2 stated resident #1's a pillow and she put his bed in #2 was unsure if his oxygen #2 left room but she continued and #1 every 30-40 minutes. NA r time, she was passing trays in and she noted he looked a resident #1 was unconscious, but still warm. NA #2 stated borway and called for a nurse, and MA #2 got the crash cart. NA #2 #4 also responded to the room	F	157					
	nurse #2 stated that resident #1 aro	hat nurse #1 asked DON to look und shift change so nurse #2							

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILU	NG	0	COMPLETED		
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F 157	she was going to be Nurse #2 said he was oxygen in place. His not responsive. Nurse to monitor resident # condition and call the decline. Nurse #2 statesident #1 was a full went to the room are blood sugar of the room ochange in his conhe was still gasping the bed. Nurse 2 said the MDS nurse told blooking good. The M resident #1 was less breathing sporadical go look at resident # physician. The physician. The physician. The physician. The physician the went into respirat started. Nurse #2 stated. Nurse #2 stated. Nurse #2 stated around 6:1 in an interview on 4/ nurse stated that it when NA #2 motlone She stated resident #1 out out to pulse so she call get the crash cart. The felt resident #1 out earlier that day is he was having troub though he didn't war	caring for him that shift. s gasping for air with his eyes were open but he was se #2 said she was instructed 1 for worsening in his in physician for further ated she was aware that I code, She stated that she und 4:15 PM to check the nom mate, and that there was dition at the time. She stated for air and writhing about in d that around 6:00 PM or so, ner that resident.#1 was not DS nurse reported to her that responsive, pale and ly. Nurse #2 said she did not 2 but rather called the cian gave an order to send a hospital but he apparently ory arrest and CPR was ated she did not chart any because none occurred until	F	157				

CENTERS FOR MEDICARE & I		MEDICAID SERVICES				OMB N	OMB NO. 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDEIVSUPPLIETVCLIA IDENTIFICATION NUMBER:] " "		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 157	anyone was taking the physician told the condition and call hit condition and call hit line a telephone interphysician recalled gabout resident #1 be and that he refused physician recalled the administered his on when he was found because is oxygen physician stated awas aturation rate wen of oxygen. The physician stated but the facility in was a full code but his on responsible was a Do Not Resulthat resident #1 was oxygen and stated go. He recalled telling signs and respirated unable to recall if he about resident #1. In a telephone interphysician stated he but if rosident #1. In a telephone interphysician stated he but if rosident #1 will distress, he would assess his breathin and called him for respiratory status of the physician states second call that after to the hospital and	ne stated she did not think nis vital signs and was aware e staff to monitor his	F	157				

STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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F 157	of time of the second On 4/5/13 at 10:30 A her expectation wou resident #1's respiral changed, the physicito the hospital for exseriousness of his control of the thospital for exseriousness of his control of the administrator with a corrective action of the resident #1 expired Review of the resident #1 expired Review of the resident was his ow requested that his for change in condition hospitalization. The physician was notified in condition and his the physician indicates in the physician indicates in the physician of the physician indicates in the physician indicates in the physician indicates in the physician was notified in the physician was	id call. MM, the administrator stated lid have been that when tory and mental status ian would be notified and sent aluation given the condition and vital signs. The sentified of the immediate and 1:00 PM. The sentified and sentified and sentified and 1:00 PM. The sentified and sentified and sentified and 1:00 PM. The sentified and sentified and sentified and 1:00 PM. The sentified and sentified and sentified and 1:00 PM. The sentified and sentified and sentified and 1:00 PM. The sentified and sentified and sentified and 1:00 PM. The sentified and sentified and sentified and 1:00 PM. The sentified and sentified and sentified and 1:00 PM. The sentified and sentified and sentified and 1:00 PM. The sentified and sentified and sentified and 1:00 PM. The sentified and sentified and sentified and 1:00 PM. The sentified and sentified and sentified and 1:00 PM. The sentified and sentified and sentified and 1:00 PM. The sentified and sentified a	F 157					

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F 157	on-line learning cours Communication " wh for communication to "All licensed nursing the DON or appropria following and attache Change, Facility polic Status which includes Validation Checklist frand Documentation congoing, -Any licensed staff m trained as of 04/05/20 report for duty until training in licensed merorientation. -24 hour nursing reposupervising or charge identification of proper and resident represe facility policy. Any diwill be corrected by the nurse reviewing the 204/05/2013 and ongo-Validation Checklist in charge of the rasid condition requiring place representative for a proper of the resident conducted by the DC weekly x 4 weeks, m x 3 quarters, and as	staff have been assigned as "Effective ich includes the SBAR tool the physician, 04/05/2013, staff will be in-serviced by ate designee regarding the id. F Tag 157: Notification of the physician of the continuous properties of Change in Resident is notification of physician, or Notification of Changes, of Notification on 04/05/2013, sember who has not been 013 will not be allowed to aining is complete. The included as additional continuous properties and per serepancies in notification and annual control will be reviewed by the enurse each shift for an orification of physician intative as needed and per screpancies in notification he supervising or charge 24 hour report, beginning will be utilized by the nurse lent with a change in hysician and resident period of 4 weeks, beginning of Change audits will be 0N, or appropriate designee onthly x 2 months, quarterly		157				

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA (2		TIPLE CO	(X3) DATE SURVEY		
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F 157	administrative team compliance with plar Validation of Notifica Mooting. Non-comp during this meeting was needed and for any non-compliant disciplined by the DC The review of the 24 with a minimum of water was nonthly reviews, x 2 quarterly x 3 quarter -Review of the Valid 5 days per week by Staff during Morning by weekly x 3 weeks quarters, and as needed reviewed by the facil Morning Meeting was monthly x 2 months, quarters, a as needed. This plan and its out the QA committee dimeeting. Any devia examined using a Ramendments to the outcomes, recomme be included in the fact Any changes to the documented in the Cappropriate staff replan. Any changes require the monitoria at the initial reviews	be reviewed by the facility 5 x per week x 4 weeks for a as stated above and tion forms during Morning liance will be discussed with Immediate notifications d the nurse (s) responsible nce re-in-serviced and ON or appropriate designee. hour report will by continued eekly reviews x 3 weeks, months, followed by s, and as needed, ongoing, ation reports will be reviewed the Facility Administrative Meeting x 1 week, followed s, followed by quarterly x 3 aded, ongoing, on of Change Audits will be lity Administrative Staff during ekly x 4 weeks, followed by followed by quarterly x 3 ad, ongoing, tecomes will be reviewed by uring the monthly QA tions of the plan will be CA approach to the issue and plan as needed. This review, andations, and monitoring will cility QA meeting minutes, plan above will be DA meeting minutes, in-serviced to changes in the made to the above plan will ag of such changes to begin schedule of 5 days/week x 1 beks; monthly x 2 months,	F	157			

STATEMENT OF DEFICIENCIES (X1) PROVIDER		(X1) PROVIDER/SUPPLIER/CLIA	ROVIDER/SUPPLIER/CLIA (X2) MULT		ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 157 F 309 SS=J	allegation was evided care nursing staff relichange in a resident the physician utilizing the 24 hour report to physician to be mad aware of the validation residents with any nursidents with any nursidents. WELL BE Each resident must provide the necessation maintain the high mental, and psychological residents.	M, verification of the credible need by interviews of direct ated to the notification of a s' status, communication with g the SBAR tool, review of identify concerns for the a aware. The nurses were on checklist for all current oted changes in condition. ARE/SERVICES FOR ING Treceive and the facility must ary care and services to attain est practicable physical,		= 309	Resident #1 expired on 04/01/2013 It is determined that all residents have the potentia to be affected. Audit of all residents advan	iced ,	4-5-13	
	This REQUIREMENT is not met as evidenced by: Based on staff, physician interviews and record review, the facility falled to assess and monitor a resident experiencing a significant change in condition (respiratory distress) and failed to seek medical intervention for a resident in respiratory distress in 1 of 3 residents sampled with a change in condition (Resident #1). Immediate Jeopardy began on 4/1/13 and was identified on 4/5/13 at 1:00 PM. Immediate Jeopardy was removed on 4/5/13 at 6:30 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (no actual harm with the potential for more than				directives was conducted by social worker to determine accuracy of such directives compared to the wishes of individual resident, as cogniappropriate on 04/05/2013. A review of the 24 hour regwas completed by the DON appropriate designee, on 04/04/2013 there is no evior of any deficient physician or resident representative.	e the as the nitively s ports N, or	4-5-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		0.00		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
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•	ovider or supplier NDS NURSING & REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301			
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F 309	minimal harm that is The facility was in the Implementation and action. Findings included: Resident #1 was add 3/18/13 with diagnose	not immediate Jeopardy). e process of full monitoring their corrective . mitted to the facility on ses of End Stage Chronic	F	309	communication or lack of assessment by nursing staff for resident's requiring such interventions All licensed nursing staff will be re-in-serviced by the DON, or		
	Obstructive Pulmonary Disease (COPD) and Emphysema. The admission Minimum Data Set (MDS) dated 3/25/13 indicated that rosident #1 had no short term or long term memory problems and no documented behavioral problems. He was coded as cognitively intact and the MDS indicated that he depended extensively on staff for all of his activities of daily living. Resident #1 was not coded as having a prognosis of loss than 6 months life expectancy. Resident #1 required continuous oxygen at 4 liters/minute using a nasal cannula.			And the state of t	appropriate designee, as to the standard criteria for monitoring resident's condition as listed be but not limited to: VS (Tempera Pulse, Respirations, Blood Prese Pulse Ox), Level of Consciousne and Responsiveness, Level of Cognition, 04/19/2013 Any licensed nursing staff who has not been in-serviced a	g elow, ature, sure, ess	4-19-13
	that he was his own his admission paper Status Resuscitation indicating he would event of a cardiac o document was date. A review of the physicsident #1 was to revery four hours. The breathing treatment	#1's medical record indicated responsible party and signed work to include the Code in Request/Order form like to be resuscitated in the respiratory arrest. This d 3/18/13. sician orders indicated that receive a breathing treatment here were no medications or a ordered that could have led for shortness of breath.			04/19/2013 will not be allowed report for duty until training i complete. All licensed nursing staff will i re-in-serviced on Documenta Standards by the DON, or appropriate designee 04/19/2	s be tlon	4-19-13

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDENSUPPLIENCLIA		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. DUILDING	COP CO Life Assumption (Assumption)	(: l	
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F 309	that resident #1 had at medium and soft A review of the Med (MAR) indicated the resident #1's oxyge liters/minute of oxyge A review of the med routine vital signs w PM. Resident #1's of follows: blood press respirations 20. In a nursing note w indicated that resid around 2:30 PM sld was clammy with a The nursing note d was in use at the tigiven a breathing the saturation increase of oxygen using a vital signs were as (low), pulse 78, resident #1 refused evaluation and he The nursing note a of nursing (DON) a physician was notion on 4/1/13 at 2:30 Situational Backgr Recommendation indicated nurso #1	#1's bowel record indicated a stool on 3/31/13 described formed. dication Administration Record at at 10:00AM on 4/1/13, in saturation was 90% on 4 gen using a nesal cannula. dical record indicated that were taken on 4/1/13 at 12:20 vital signs at that time were as sure 132/94, pulse 110, written by nurse #1, she ent #1 was observed at or imped over in his chair. He in oxygen saturation of 81% id not indicate if his oxygen me he was found. He was reatment and his oxygen and to 95% on 4 liters/ minutes hasal cannula. Resident #1's follows: blood pressure 82/60 epiration 48 (elevated) and F. The nursing note indicated at to go to hospital for did not want his family notified, also indicated that the director assessed resident #1 and the	F 30	All licensed nursing staff in-serviced by the DON of appropriate designee regions the following: F Tag 309: Quality of Car Facility Policy on Change Resident Status which in notification of physician Validation Checklist for of Changes, Practice Gu Notification of Changes, Documentation of and Italian in the Italian of Changes, Documentation of Changes, Practice Gu Notification of Chang	garding re, e in ncludes , Notification ideline for , fication, aff who d as of allowed training is e included in licensed d annual s ted included in licensed d annual	4-19-13	

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F 309	anxious. This form instructed the staff monitor his vital sig DON was aware of	go 15 In), short of breath and Indicated that the he physician to observe resident #1 and Ins. This form indicated the the physician's directive. Instration record (MAR)	F	309	weekly x 3 weeks, monthly x 2 months, quarterly x 3 quarters. Beginning 04/05/2013, and ong This audit will identify the validathrough documentation of monitoring applicable resident	ation'	1-19-13 Ongoing
	dated 4/1/13, indica #1 was not respon- medications. The Maide (MA) #1 notifi- condition.	ated that at 4:34 PM, resident sive enough to take his AAR noted that the medication ed nurse #2 of his change of			condition and related notification of physician and resident representative as appropriate. 24 hour reports will be reviewed	on d	9-13
	no ongoing assess PM until approximated medical services (no evidence of any	of resident #1's medical record indicated ing assessment from approximately 2:30 approximately 6:15 PM when emergency services (EMS) was notified. There was ince of any ongoing assessment of #1's respiratory or mental status			by the facility administrative tea 5 x per week x 4 weeks for compliance with plan and Valida of Notification forms during Mo Meeting. Non-compliance will b discussed during this meeting w	ation rning e	4-19-13 and ongoing
	approximately 6:1 department and the PM and cardio put was in progress befound without a put unresponsive. His Resident #1 was put in an interview on stated that on 4/1, she and MA # 1 at the bed. Nurse # look at resident # him out but he refeated that the DC stated that the DC	MS report, on 4/1/13 at 5 PM, the call came into the any arrived on the scene at 6:27 Immonary resuscitation (CPR) by facility staff. Resident #1 was also, not breathing and skin was cold to the touch. For the skin was cold to send fused to go to hospital. Nurse #1 DN stated the hospital could not skin was cold to the skin			immediate notifications made a needed and the nurse(s) respon for any non-compliance re-in-se and disciplined by the DON or appropriate designee. 04/05/20 ongoing. The review of the 24 hour report be continued with a minimum or reviews x 3 weeks, monthly reviews x 2 months, quarterly reviews x quarters, and as needed.	sible rviced 13 and t will if weekly	4-19-13 and ongary

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F 309	not do. Nurse #1 stal check resident #1 for stated the DON state was his problem? "I resident #1 for an im medium amount of h suppository was adn removed. Nurse #1 #1's medical record bowel movement. Si physician and compliphysician instruction monitor his vital sign changes in his respi #1 could not recall if of dis-impacting resi suppository. Nurse #1 nurse #2 were prese when the physician she also reported to nurse, in her shift of instructions. Nurse #1 full code and she did DON and physician not recall if she spewas a full code but stated his code statt form. Nurse #1 state nurse #2 went to the prior to her leaving shift. In an interview on 4 aide #1 (MA) stated getting resident #1 approximately 2:30 refused to go to the	ed the DON instructed her to an impaction. Nurse #1 ad " did you over think that Nurse #1 stated she checked paction and there was noted		309	Review of Advanced Directives A and Notification of Change Audit be reviewed by the facility Administrative Staff during Morr Meeting weekly x 4 weeks, monty 2 months, quarterly x 3 quarterly and as needed, 04/04/2013 and This plan and its outcomes will be reviewed by the QA committee of the monthly QA meeting. Any do of the plan will be examined using RCA approach to the issue and amendments to the plan as need This review, outcomes, recomm and monitoring will be included facility QA meeting minutes. And changes to the plan above will be documented in the QA meeting appropriate staff re-in-serviced changes in the plan. Any changes made to the above plan will require the monitoring of such changes to begin at the initial review so of 5 days/week x 1 week, week weeks, monthly x 2 months, quit x 3 quarters, and as needed.	ning thly, rs ongoing e during eviations ng a ded. endation in the ny oe minutes, to es juire hedule kly x 3	

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F 309	resident requested asked NA #1 to st stated sometime simedication cart, the requested a Duco In an interview on on 4/1/13 at appropriate the resident #1 alread 1 asked her to stated the removed couldn't breathed treatment in place #1 and the DON complete her rour In an interview on stated that nurse #1. She said he vireatment in progroom. She said he vireatment #1. She check resident #1 instructed nurse #1 instruct	age 17 bom and told her another if a pain medication. MA #1 ay with resident #1. MA #1 thortly after she returned to her the DON approached her and lax suppository for resident #1. 4/4/13 at 130 PM, NA #1 stated eximately 2:45 PM, she saw by in the bed, NA #1 stated MA # y with resident #1 until nurse #1 tated resident #1 until nurse #1 tated resident #1 had a mask ling at breathing treatment. She did that mask and stated he NA #1 told him to keep by NA #1 stated that once nurse were in the room, she left to hads and report off to NA #2. 4/4/13 at 2:00 PM, the DON #1 asked her to look at resident was in the bed with a breathing ress when she entered the he was in a hospital gown and he he and that this was unusual for stated she instructed nurse #1 to for an impaction. She #1 to administer a suppository, she did not check the medical her resident #1 last had a bowel she ensured resident #1's head had his oxygen was in place, hurse #1 called the physician of shift change. The DON stated ident #1's code status. The DON t actually assess resident #1 but hit during the impaction removal	F 30					

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by nur reside the rod his ox was u station could aware asked for an that re hospit overw reside she ha was w it was stool e reside aware directi impac rease stated again PM. In an i stated beginr him, h unable his ox stated stated stated stated stated	nt #1's vital signor while he waygen was in place. The DON state when nurse #1 not recall if nurse #1 if she impaction because the modern was all unnocessaril helmed because his being admit ad to be sure a arranted. The Language and the modern was that nurse #1 is distress that nurse #1 is ve. The DON state her decisions the conditions he did not maprior to leaving an energency of her shift e was thrashing to respond to ygen was in place she thought rethe DON, nursing at the nursing the	N stated awareness of ms. She stated she stayed in is cleaned up and ensured ince and the head of his bad atted she was at the nursing 1 notified the physician. She is #1 made the physician full code status. The DON is had checked resident #1 muse she wanted to be sure not being sent out to the y. The DON stated she felt is of the acuity of the itted to the facility and stated trip to the emergency room DON stated she did not think at the time and felt that the idd be effective in easing in the DON stated she was was not satisfied with her lated that could have in not to return to the floor to in of resident #1. The DON ake contact with floor staff work that day around 6:00 more stated when she saw in a stated when she saw in glabout in the bed and ther questions. She stated ince at the time, MA #2 is #1 and nurse #2 were in station and no nurse went to see resident #1, MA #2	F	309			

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 309	hospital. Nurse #1 tol not to send him out. I physician told them to decline in his condition stated that she was not the room to see resided 4:34 PM, she tried to scheduled medication enough to take his mourse #2 about resided MA #2 stated nurse # assess resident #1 to stated that around 6: announced and she aroom to find the MDS. In a telephone intervint NA #2 stated that on #1 told her that resided all day and she need NA #2 stated she way vital signs or what concrete #2, NA #2 state eye on him " by nurse to room to see resided appeared to be in disdistress as uncomfor unable able to respond gasping for breath. Not head was off of the pack on pillow. NA #2 was in place. NA #2 stated passing trays and gothe looked worse. She	y were sending him to the id her that the DON told her Nurse #1 stated the promotion for any further on and call him back. MA #2 tot aware if nurse #2 went to lent #1. MA #2 stated that at give resident #1 's his in but he was not responsive edicine. She stated she told ent #1's change in condition. #2 did not go to the room to the her knowledge. MA #2 15 PM, she heard a code responded to resident #1's income initiating CPR. New on 4/5/13 at 11:12 AM, 4/1/13 around 3:00 PM, NA ent #1 had not been himself to to keep an eye on him. In some instructed to get any anditions she was ton tolify ed she was told to "keep an er #2. NA #2 stated she wontent #1 and noted that he stress. She described table, moving around in bed, ands to her questions and the #2 stated resident #1's billow and she put his bed 2 was unsure if his oxygen	£	309				

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F 309	a nurse. The MDS nuroom and started CPF NA #2 stated that nurroom and nurse #2 color and nurse #2 color and nurse #2 color and nurse #2 stated that rat resident #1 around also went into the roos she was going to be considered to monitor this condition and call decline. Nurse #2 staresident #1 was a full went to the room and blood sugar of the room ochange in his condition was still gasping for the bed. Nurse 2 said the MDS nurse told his looking good. The MD rosident #1 was less to breathing sporadically go look at resident #2 physician. The physic resident #1 out to the he went into respirato started. Nurse #2 stated she did not after MA #2 told her he was stated she did not after MA #2 told her her started was easily to the color after MA #2 told her her started was easily to the ment and until he color was started was easily told her her was easily told h	the doorway and called for rise and MA #2 came to the R. NA #2 got the crash cart. se # 4 also responded to the alled 911. The won 4/4/13 at 3:20 PM, burse #1 asked DON to look shift change so nurso #2 m to see resident #1 sinco caring for him that shift. It gasping for air with his eyes were open but he was resident #1 for wprsening in the physician for further ted she was aware that code. She stated that she and 4:15 PM to check the own mate, and that there was dition at the time. She stated for air and writhing about in that around 6:00 PM or so, for that resident #1 was not DS nurse reported to her that responsive, pale and w. Nurse #2 said she did not	F	309			
	4.00 FWI INBURGATION.	100 00 HZ 2000 \$10 00 10			1		

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F 309	responsive. Nurse #; ordered a breathing than this next one was planned to administe resident #1 coded be in an interview on 4/4 nurse stated that it when NA #2 motione. She stated resident #1 breath. His oxygen was sternal rub without no pulse so she callenget the crash cart. The she felt resident #1 sout earlier that day sinh was having trouble though he didn't wanthe was not mentally I rational decision. She anyone was taking his the physician told the condition and call him. In an interview on 4/5 stated around 6:00 P was announced on the responded to the roo MA #2 were performing they took over the composition of the compositio	ed that resident #1 was not 2 indicated resident #1 was reatment every hour hours due at 6:00 PM and she in the breathing treatment but fore she get to administer it. I/13 at 1:50 PM, the MDS as around 6:00 PM or so differ for some to room. If was lying on side gasping as in place. She performed a reaction, Resident #1 had did a code and told NA #2 to be MDS nurse stated that hould have been sent him ince he was a full code and be breathing. She said even to go, she felt resident #1 in any condition to make a stated she did not think is vital signs and was aware a staff to monitor his	F	309			

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•	ROVIDER OR SUPPLIER NDS NURSING & REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD GROSS REFERENCED TO THE APPROPR DEFICIENCY)	DE.	(X5) COMPLETION DATE
F 309	when he was found s because is oxygen sa physician stated awar saturation rate went u of oxygen. The physician stated in the adequate intervention could not recall if the him that resident #1 was and that he thought h (DNR). He recalled the on 4 liters/minutes of as high as he could staff to monitor his vit status. The physician was called again that in a telephone interviphysician stated he do but if resident #1 was distress, he would ha assess his breathing and called him for an respiratory status or of the physician stated second call that after to the hospital and he evaluation. The physic fime of the second in an interview on 4/6 administrator stated heen that when residemental status change	lumped over in the chair lumped over on 4 liters/minute clan stated that because his a improved after the lumper over a feel observation was an at the time. The physician staff at the facility informed was a full code but he knew his own responsible party le was a Do Not Resuscitate that resident #1 was already oxygen and stated that was o. He recalled telling the al signs and respiratory was unable to recall if he day about resident #1. Lew on 4/4/13 at 5:00 PM, the id not give specific orders experiencing respiratory we expected the nurses to and respirations, vital signs y changes in his mental status, he thought he received a moon asking to send him out for ician stated he was unsure call.	F	309			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
 			A boico		· · · · · · · · · · · · · · · · · · ·		С
		345481	B. WING			04/	/05/2013
	OVIDER OR SUPPLIER NDS NURSING & REHAE	BILITATION CENTER		4	REET ADDRESS, CITY, STATE, ZIP CODE 100 PELT DRIVE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST 8E PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DATE
F 309	Continued From page given the seriousness signs. The administrator was jeopardy on 4/5/13 and What corrective action those residents affect resident #1 expired. What corrective action those residents having the same deficient project is determined that a potential to be affected. Audit of all residents conducted by the soci accuracy of such direct wishes of the individual appropriate on 04/05/-A review of the 24 ho by the DON, or appropriate on 04/04/2013 there is no physician or resident to communication or lack staff for resident's rewith the temporal will be made practice will not occurrate will be changes will be made practice will not occurrate and ard criteria for metallicensed nursing standard criteria for metallicensed standard criteria for metallicensed nursing standard criteria for metallicen	e 23 s of his condition and vital s notified of the immediate ad 1:00 PM. In will be accomplished for ed by the deficient practice? on 04/01/2013 In will be accomplished for g potential to be affected by actice? all residents have the d. advanced directives was ial worker to determine the ctives as compared to the all resident, as cognitively 2013 our reports was completed priate designee, on the ovidence of any deficient representative is of assessment by nursing quiring such interventions of put into place or systemic to ensure that the deficient cts of the designee, as to the contoring resident is		309	DEFICIENCY)		
	(Temperature, Pulse,	Level of Consciousness and al of Cognition on ng.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIET/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		345481	8. WNG	g .			C
NAME OF PE	ROVIDER OR SUPPLIER			7	REET ADDRESS, CITY, STATE, ZIP CODE	<u>U4/</u>	05/2013
WOODLA	NDS NURSING & REHAB	SILITATION CENTER		1	400 PELT DRIVE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ìΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	in-serviced as of 04/0 report for duty until tra-All licensed nursing s Documentation Stand appropriate designee 04/05/2013 and ongoi-All licensed nursing s the DON or appropria following and attached Care, Facility Policy o Status which includes Validation Checklist for Practice Guldeline for Documentation of Not Any licensed nursing in-serviced as of 04/0 report for duty until tra This information will b training in licensed nure-orientation. For applicable resident targeted monitoring) 5 documentation will be followed by weekly x 3 monthly x 2 months, for quarters. Beginning 0-This audit will identify documentation of mons condition and related and resident representation and related and resident representation of mons condition and related and resident representation of mons condition and related and resident representation of mons condition and related and resident representation will performance often? -24 hour reports will be administrative team 5 compliance with plantation-compliance will be compliance will be comp	5/2013 will not be allowed to sining is complete. Itaff will be re-in-serviced on ards by the DON, or (see attached) on ing. Itaff will be in-serviced by the designee regarding the diff will be in-serviced by the designee regarding the diff will be in-serviced by the designee regarding the diffication of Changes, in Change in Resident notification of Changes, Notification of Changes, in Italian in the allowed to sining is complete. In Included as additional resing orientation and annual with the service of	F	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						,	c	
		345481	B. WNG			04/	05/2013	
NAME OF PROVIDER OR SUPPLIER WOODLANDS NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL) REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION \$1		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	9E	(XS) COMPLETION DATE	
F 309	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOTTAG GROSS-REFERENCED TO THE APPR				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X9) DATE SURVEY COMPLETED	
		345481	B. WING _			С	
NAME OF P	ROVIDER OR SUPPLIER	34340 [04/05/2013	
	NDS NURSING & REHAE	NLITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NO. 28301		•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 309	aware of the validation	26 n chocklist for all current ed changes in condition.	F 3				