

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

JUL 24 2013

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/11/2013
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #OBUT11, Intake #NC000	F 000	Disclaimer Statement:	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, and record review the facility failed to ensure that 1 of 1 residents (Resident #137) with a rash/dermatitis was seen by a dermatologist for the appropriate problem as ordered by the resident's primary physician. Findings included: Resident #137 was admitted on 01/06/12. Her documented diagnoses included perineal rash/dermatitis, dementia, and urinary retention. On 09/18/12 "At risk for skin breakdown or development of further pressure ulcers related to: cognitive impairment, incontinence" was identified as a problem in the resident's care plan. Interventions to this problem included "Staff to report to nurse any red or open areas", "Apply protective barrier cream", "Lubricate skin with moisturizing lotion. If a heavier moisturizer is needed, use a skin cream".	F 309	Tower Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Tower Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tower Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	8/8/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator

(X6) DATE

7/24/13

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.

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/11/2013
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309	<p>Continued From page 1</p> <p>Beginning on 11/12/12 weekly Flowsheets of Non-Ulcer Skin Condition documented that the resident had a red raised pimple rash to her perineal area. They also documented that the resident's scratching in this area made it difficult for the perineum to heal.</p> <p>A 03/13/13 physician order discontinued the resident's Atarax and initiated Claritin 10 milligrams (mg) daily (QD) x 30 days for itching. There were no further physician orders for medications to control itching.</p> <p>A 04/8/13 physician progress note documented, "...Also talked with wound nurse-patient continues with perineal rash with baseline incontinence. Currently using A and D ointment and ketoconazole/bactroban in peri-area. Does not appear to be infected any longer. (Question) if Nystatin powder would be more effective. Patient has been on current regimen x 2 months."</p> <p>A 04/8/13 physician order discontinued the use of ketoconazole (Nizoral) and bactroban, and initiated use of Nystatin powder to be applied to perineal rash twice daily (BID) for fungal dermatitis. The BID Nystatin powder was continued until 06/16/13.</p> <p>A 04/19/13 physician progress note documented, "Note for 'skin changes': Patient seen today per nursing request for vaginal redness/irritation with excoriation noted. Patient currently receiving Nystatin powder to periaerea/vaginal area along with A and D ointment to groin. Wound nurse concerned that with frequent incontinent episodes--difficult to keep patient dry. Patient</p>	F 309	<p>F309</p> <p>Resident 137 is scheduled to see the dermatologist on 8/05/2013.</p> <p>A 100% audit was completed by DON, QI Nurse, and ADON of all physician orders for consults dating back to 4/1/2013 to ensure appointments were scheduled per physician's order, resident was actually seen, any cancelled appointment was rescheduled with MD notification and resident seen for the appropriate problem. Any areas identified were corrected for the resident's individual needs.</p> <p>The DON and/or QI Nurse, ADON, day shift supervisor, evening shift supervisor, night Shift supervisor or liscenced nurse will complete In-service for all nurses and appointment scheduler regarding new process and tracking tool for consult appointments.</p> <p>The DON and/or QI Nurse, ADON, day shift supervisor, evening shift supervisor, night Shift supervisor or liscenced nurse will complete In-service for all nurses regarding documentation when family members cancel or request to reschedule appointments and notifying the MD.</p> <p>The SDC will inservice all new nurses hired during orientation</p>	8/8/13
-------	--	-------	--	--------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 2</p> <p>noted urinating at times during time that creams are being applied when turned on side/position change. Previously with Foley due to urinary retention, however, due to patient persistently pulling out Foley and successfully voiding with trialed d/c (discontinuation) of Foley--patient currently using briefs. For several months have been attempting with bactroban/steroid + antifungal cream/ketoconazole cream to resolve vaginal excoriation rash with minimal improvement....Today's impression: chronic urinary incontinence with frequent urination causing irritation/moist environment. Nystatin powder helping somewhat. however, still skin red with scabbed area/excoriations. Due to multiple months with trial of bactroban/steroid + antifungal cream/ketoconazole cream and now Nystatin with only minimal improvement--will refer to dermatology for further evaluation...."</p> <p>A 04/19/13 physician order documented Resident #137 was to have a dermatology consult for persistent vaginal dermatitis.</p> <p>A review of the resident's 05/13/13 dermatology Report of Consultation revealed the nursing home failed to provide a reason for the appointment. Findings from the dermatology exam documented, "erythema with chafing on low abdomen." The documented diagnosis was "dermatitis". Under the Recommendations section it documented, "These are based on very limited information that was not provided by the nursing home or the patient (didn't speak/demented) or her (family member) who was present but had no idea of the purpose for her visit."</p>	F 309	<p>Consults to be monitored by the Scheduling Coordinator utilizing a QI Consult Audit tool to track consult orders, date of scheduled appointment, and if resident was seen/not seen, if resident seen for the appropriate problem, and if paperwork returned with resident. Consult orders to be tracked through the pink slip process and follow through to be monitored with the QI Consult Audit Tool for one time weekly for four weeks then one time monthly for three months.</p> <p>The DON will review the results of the QI Consult Audit tool one time weekly for four weeks then one time monthly for three months to assure the system is working and facility is in compliance.</p> <p>The Administrator will submit results of the audits to the Quality Improvement Executive Committee Meeting monthly for review, recommendations, and monitoring of continued compliance in this area.</p>	8/8/13	

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 3</p> <p>Record review revealed no further dermatology consults for Resident #137.</p> <p>Physician progress notes from 04/24/13, 04/26/13, 05/31/13 and 06/05/13 did not address Resident #137's perineal rash/dermatitis.</p> <p>The resident's 06/05/13 Quarterly Minimum Data Set (MDS) documented she had short and long term memory impairment, her decision making skills were severely impaired, she experienced moisture associated skin damage, and the staff was applying ointments to the resident's skin.</p> <p>A 07/09/13 Flowsheet of Non-Ulcer Skin Condition documented Resident #137 had a chronic red raised pimple rash to her groin and buttocks.</p> <p>At 2:40 PM on 07/10/13 an observation revealed Resident #137's peri-anal area was deep red and swollen. The attending nurse reported the resident had this rash for a long time and was a "digger". She stated the resident was receiving A and D ointment and Mystatin powder twice daily. She explained the staff did not use barrier cream because it tended to pull the skin off when the resident was being cleaned up. Resident #137 moaned and whimpered slightly when sanitary wipes were used to cleanse the peri-anal area during incontinent care.</p> <p>At 4:30 PM on 07/10/13 nursing assistant (NA) #2, who cared for Resident #137 on second shift, stated the resident was confused, total care, totally incontinent, and wore a diaper She reported she checked/changed this resident when she began her shift, when the resident finished</p>	F 309			

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 4</p> <p>eating supper, before she put the resident to bed, and just before she completed her shift. She commented Resident #137 had a very red pimply rash in the vagina and bottom area which the treatment nurse was caring for. According to the NA, sometimes the resident complained of pain in the rash area when she was attempting to turn and reposition the resident. NA #2 stated the resident's rash got better, reappeared, and then got worse. She was unsure how long the resident had the rash, but commented it was not a recent development. The NA reported she placed barrier cream on the resident's bottom. She commented the resident scratched herself a lot in the peri area, and there would be feces everywhere. She stated that nothing could be done to prevent this scratching.</p> <p>At 4:48 PM on 07/10/13 Nurse #3, who cared for Resident #137 on second shift, stated even though the resident was confused and could get agitated, she could make her needs known. She reported the resident "put her hands in her privates a lot-digging". The nurse commented the facility had tried different creams on her red, rashy perineal area/buttocks. She explained the rash came and went.</p> <p>At 10:26 AM on 07/11/13 Nurse #4, a treatment nurse, stated Resident #137 had a perineal rash when she started working with her six months ago. She reported when she first began treating the resident her perineum was dark red with pimples (shaped like bubbles), and the resident had some excoriation secondary to scratching. She commented now the affected area was still the same except it was smaller, and the area was not quite as bright red. Nurse #4 stated the</p>	F 309		

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 5</p> <p>resident was still scratching. When this occurred she reported the staff tried to redirect the resident, but she did not know of any other interventions which the facility tried to lessen the problem with itching. She commented Resident #137 had completed a regimen of Nystatin powder, and always received A and D ointment.</p> <p>At 10:48 AM on 07/11/13 the facility's scheduler reported she attempted to get Resident #137 appointments with two dermatologists, but was unsuccessful. According to the scheduler, on her third attempt an appointment was set up for the resident, but because the resident was new to this practice, there was a delay. She explained this was why it took so long to get the dermatology appointment on 05/13/13 (which was ordered by the physician on 04/19/13). She commented that either the staff member who prepared the packet of information to send with Resident #137 on her 05/13/13 consult forgot to send a copy of the 04/19/13 physician order or the dermatology office did not realized the copy was in the packet. However, the scheduler confirmed that no one in the facility completed the section on the Report of Consultation sheet which specified the reason for the consult.</p> <p>At 11:02 AM on 07/11/13 NA #3, who cared for Resident #137 on first shift, stated the resident was totally incontinent, wore a diaper, and had diaper sores on her bottom. She reported the resident had the sores for the three months that she had cared for her. She was not aware of the resident scratching herself in the affected area, but she stated she applied cream to the resident's bottom after incontinent care. NA #3 commented when cleaning the resident, the resident would</p>	F 309		

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 6</p> <p>sometimes say that she was in pain or that the care was hurting her.</p> <p>At 12:13 PM on 07/11/13 Nurse #5, who cared for Resident #137 on first shift, stated the resident sometimes resisted care such as baths and incontinent care, wore a diaper, and was sometimes a heavy wetter. He reported seeing the resident digging and scratching her bottom and vaginal area which was broken out in a rash in the past but not recently. He commented the only intervention he was aware of to keep the resident from causing damage when scratching was to keep her fingernails trimmed and smooth.</p> <p>At 12:34 PM on 07/11/13 the director of nursing (DON) stated when an appointment for a consult was canceled by the facility and there had been previous conflicts with the family's schedule and resident's appointments, her expectation was for the facility and family to work in conjunction to reschedule the consult as soon as possible.</p> <p>At 12:40 PM on 07/11/13, during a telephone interview, a family member of Resident #137 stated she accompanied the resident to appointments, and there was only one time, and she thought that was last month, when she asked for a dermatology appointment to be rescheduled because she had a physician appointment herself on the same day. She commented the facility never called her back with the new date for the appointment, and she was not aware of the resident currently having an appointment on the books at the dermatologist.</p> <p>At 12:52 PM on 07/11/13 the dermatology office attended by Resident #137 on 05/13/13 reported</p>	F 309		

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 7 a follow-up appointment was scheduled for the resident on 05/30/13, but on 05/24/13 an unknown party called the office, and had the appointment rescheduled to 06/10/13. On 06/10/13 the office stated "the patient" called and canceled the appointment that same day. The office commented on 07/11/13, after surveyor intervention, someone called and set up an appointment for Resident #137 to be seen again by the dermatologist on 08/05/13.	F 309			
F 329 SS=D	483.25(I) 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 drugs.	F 329	F329 A medication error report was completed for resident 20 on 7-11-2013 by the QI Nurse and MD notified with clarification order obtained for medication to include correction of Medication Administration Record. A 100% audit of Physician's orders was completed on 7/12/2013 and 07/15/2013 by DON, ADON, and QI Nurse for months of July 2013 to ensure current orders match the Medication Administration Record. Any areas identified were corrected through notification of MD and medication errors reports as appropriate. The DON and/or QI Nurse, ADON, day shift supervisor, evening shift supervisor, night Shift supervisor or liscenced nurse to complete In-service with all licensed nursing staff on process of MAR Checks at end of month. The SDC will Inservice all new hired licensed nurses during orientation.	8/8/13	

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to discontinue two medications for 1 of 10 sampled residents (Resident #20) whose unnecessary medications were reviewed. Findings included: Resident #20 was admitted to the facility on 8/25/11 with cumulative diagnoses of insomnia, depression and hypertension. Resident #20's Quarterly Minimum Data Set (MDS) dated 6/7/13 showed that Resident #20 was severely cognitively impaired. Review of the Physician Telephone Orders dated 6/17/13 showed an order to discontinue the use of trazodone and melatonin (medications used for insomnia) due to Resident #20 being overly sleepy and lethargic. Review of the June Medication Administration Record (MAR) showed the orders for the melatonin and trazodone had been yellowed out and DC (discontinue) 6/17/13 written next to them. Review of the July Physician's Orders Sheet listed melatonin and trazodone. They were scheduled to be administered at 8:00 PM every day. Review of the July MAR showed both the melatonin and trazodone were administered to Resident #20 from July 1-10 even though the medications had been discontinued.	F 329	Facility nurses will continue to complete Medication Administration Record checks compared to MD orders at month end to assure current MD orders and Medication Administration records for the next month are accurate. DON, QI Nurse, ADON, will complete an audit of 10 percent of resident population's Medication Administration Records comparing to current MD orders to assure current MD orders are accurate on the Medication Administration Record utilizing a QI Audit Tool weekly for four weeks then monthly for three months. The Administrator will submit results of the audits to the Quality Improvement Executive Committee Meeting monthly for review, recommendations, and monitoring of continued compliance in this area.	8/8/13	

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 9</p> <p>In a telephone interview on 7/11/13 at 9:35 AM Nurse #2 stated she performed the secondary check on the July physician orders reconciliation. The process for checking the orders included comparing the previous month's physician orders to the current month's physician orders. It also included checking any telephone orders received for the resident during the previous month and making sure any new orders were placed on the MAR and that any discontinued orders were removed from the new MAR. She indicated she was usually very thorough and did not know how she had missed taking the discontinued medications off the July MAR.</p> <p>In a telephone interview on 7/11/13 at 9:38 AM Nurse #1 indicated she was the nurse who performed the initial reconciliation check of the July physician orders. Nurse #1 corroborated the process for checking the orders provided by Nurse #1. She stated she did not know what had happened and could not remember why the orders were left on the July MAR when they should have been discontinued.</p> <p>In an interview on 7/11/13 at 1:15 PM the Director of Nursing (DON) stated she expected the nurses who performed the initial and secondary checks for the new months orders to compare the previous month's MAR to the current month's MAR. She also expected them to check the telephone orders to see if new medication orders were written or if medications had been discontinued. She indicated she felt it was an oversight on the part of the two nurses who had done the order reconciliation check. She stated that although she occasionally would check over</p>	F 329		

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/11/2013
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329 F 371 SS=E	<p>Continued From page 10 the MAR's when the reconciliation had been completed, it was not done regularly.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep hot foods at or above 135 degrees Fahrenheit during the operation of the trayline. Findings included:</p> <p>At 11:32 AM on 07/10/13 a calibrated thermometer was used to check the temperature of hot foods on the steam table. The mashed potatoes registered 165 degrees Fahrenheit, the baked chicken registered 170 degrees, the cream of chicken soup registered 140 degrees, the puree Swiss steak registered 160 degrees, the puree noodles registered 140 degrees, and the puree fried okra registered 170 degrees.</p> <p>The lunch trayline began operation at 11:45 AM on 07/10/13.</p> <p>At 11:48 AM on 07/10/13 the cook placed four plates of food on a shelf above the steam table.</p>	F 329 F 371	<p>F371</p> <p>No residents were affected by this deficient practice.</p> <p>Hot food Items identified as not meeting temperature requirements that were pre-plated were discarded by the Cook on 7-10-2013 and food items in steam table were reheated to 165 degrees for 15 minutes to assure a safe temperature prior to serving residents.</p> <p>The Dietary Director inserviced all Cooks and Dietary Aides on 7-11-2013 regarding plating of food specifying that food should not be pre-plated before the cook indicates what should be on the plate and that the steam table should be checked prior to placing food pans in it for heating to assure it is heating properly. If the steam table is not heating properly, then to notify Maintenance staff immediately. Any hot food identified under 140 degrees must be immediately removed and reheated to 165 degrees for 15 minutes prior to serving. Any new hires in Dietary will be inserviced following general orientation on this area.</p>	8/8/13

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/11/2013	
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 11</p> <p>Puree foods were on one of those plates.</p> <p>At 11:58 AM on 07/10/13 the "caller" on the trayline retrieved the plate of puree foods off the shelf above the steam table, and placed it on a tray to be sent out to a resident.</p> <p>At 11:59 AM on 07/10/13 a calibrated thermometer was used to check the temperature of puree foods on this plate. The puree Swiss steak registered 120 degrees Fahrenheit, the puree noodles registered 112 degrees, and the puree okra registered 108 degrees.</p> <p>At 12:07 AM on 07/10/13 the cook filled two side dishes with fried okra, and placed the dishes on top of a tray pan lid which was laid across the back of the steam table.</p> <p>At 12:10 PM on 07/10/13 one of the side dishes was placed on a resident tray. The temperature of the okra in the other side dish registered 118 degrees Fahrenheit when checked using a calibrated thermometer. The fried okra still in the tray pan in the steam well registered 145 degrees.</p> <p>At 12:15 PM on 07/10/13 cream of chicken soup and mashed potatoes were placed on resident trays.</p> <p>At 12:17 PM on 07/10/13 the temperature of the foods in the steam well at the far right end of the steam table were checked using a calibrated thermometer. The mashed potatoes registered 115 degrees Fahrenheit, the cream of chicken soup registered 103 degrees, and the baked chicken registered 112 degrees. Upon examining</p>	F 371	<p>The Dietary Director will complete temperature checks of hot foods at the beginning of random selected meal service times and during the middle of the meal service time to assure that that hot food temperatures are appropriate utilizing a Steam Table QI Audit Tool weekly for eight weeks.</p> <p>The Administrator will review the Steam Table QI Audit Tool weekly for eight weeks to assure the system is working and the facility is in compliance.</p> <p>The Administrator will submit results of the audits to the Quality Improvement Executive Committee Meeting monthly for review, recommendations, and monitoring of continued compliance in this area.</p>	8/8/13

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 12 the steam table, the dietary manager (DM) stated someone forgot to turn the end steam well on. At 12:40 PM the last cart of resident trays left the kitchen. At 9:25 AM on 07/11/13 the DM stated, per federal regulations, hot foods should remain at least 140 degrees Fahrenheit during the operation of the trayline, but personally she preferred hot foods to be at least 155 to 160 degrees when they left the kitchen to allow for some cool down as they were delivered to residents. She reported dietary employees were trained not to "plate up" food in advance. She explained the cook was trained to wait until the "caller" called out the diet prescription and dislikes before placing the food in kitchenware. The DM commented all cooks were responsible for checking to make sure the wells were turned on high before the trayline began operation. At 9:43 AM on 07/11/13 the cook, who was observed working on the lunch 07/10/13 trayline, stated she was usually prepared a regular, ground, and puree plate to sit on the shelf above the steam table so she could keep up with the "caller" during the operation of the trayline. She reported all hot food on the steam table should remain at 140 degrees Fahrenheit or above while the trayline was operating. She stated as the breakfast cook and lunch cook transitioned responsibilities on 07/10/13 they must have forgotten to check to make sure all steam wells were turned on their highest setting for the lunch meal.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	F441 The DON placed the isolation sign on resident #111's door on 7/10/13.	8/8/13	

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 13 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	The DON completed a 100% audit to check that all other isolation carts had signs stocked and that any other residents on isolation had the appropriate signage posted for their individual needs. The DON, QI Nurse, ADON, day shift supervisor, evening shift supervisor, night Shift supervisor or liscenced nurse inserviced liscenced nurses on components needed for all types of isolation precautions to include contact isolation and signage. The Infection Control nurse will monitor residents who are on isolation to assure isolation signs are posted as appropriate weekly for four weeks then monthly for three months utilizing a Isolation QI Audit Tool. The DON will review the Isolation QI Audit Tool weekly for four weeks then monthly for three months to assure the system is working and the facility is in compliance. The Administrator will submit results of the audits to the Quality Improvement Executive Committee Meeting monthly for review, recommendations, and monitoring of continued compliance in this area.	8/8/13	

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interviews, the facility failed to post the approved Statewide Program for Infection Control and Epidemiology (SPICE) isolation signs outside the resident's door (Resident #111) for 1 of 1 observed rooms. Findings included:</p> <p>A review of the Issues in Infection Control for Nursing Homes provided by SPICE showed that isolation signs must be posted on the door to the resident's room. The SPICE program has been considered a standard by the Centers for Disease Control (CDC) as a tool for communicating the procedures that healthcare workers, family and visitors should follow to prevent cross transmission.</p> <p>A review of the Physician Telephone Orders dated 6/26/13 showed an order for contact precautions for Resident #111.</p> <p>An observation on 7/8/13 at 10:43 AM during the initial tour of the facility did not show any isolation signs posted on resident doorways. Personal Protective Equipment (PPE) was seen hanging over the door to Resident #111's room.</p> <p>In an interview on 7/9/13 at 8:53 AM Nurse #1 stated that resident #111 was on contact isolation precautions.</p> <p>In an observation on 7/9/13 at 10:58 AM PPE was seen hanging over Resident #111's door. There was no isolation sign posted on the door.</p> <p>In an observation on 7/9/13 at 4:52 PM PPE was</p>	F 441		

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 15</p> <p>seen hanging over Resident #111's door. There was no isolation sign posted on the door.</p> <p>In an interview on 7/9/13 at 4:53 PM Nurse #2 stated that resident #111 was on contact isolation precautions.</p> <p>In an interview on 7/9/13 at 4:57 PM Nursing Assistant (NA) #1 indicated Resident #111 was on contact isolation precautions. She stated if she did not know what kind of precautions were needed she would ask the nurse. She indicated visitors should see the PPE hanging on the door and ask the nurse what it was for.</p> <p>In an observation on 7/10/13 at 8:38 AM there was PPE hanging over the door but no isolation sign was posted on Resident #111's door.</p> <p>In an interview on 7/10/13 at 3:48 PM the Housekeeping Manager indicated there should be a brightly colored isolation sign on the door to any resident's room where isolation precautions were needed.</p> <p>In an interview on 7/10/13 at 4:14 PM the Infection Control Nurse stated that although isolation signs were available to be posted it was facility policy not to post isolation signs on the doors to resident rooms. A review of the isolation sign provided by the Infection Control Nurse for Contact Precautions read, "Visitors must report to Nursing Station before entering." There were four interventions listed: wash hands, wear gloves, wear gown if anticipating touching contaminated items and use patient dedicated or single use equipment.</p>	F 441			

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 16 In an interview on 7/10/13 at 4:25 PM the Director of Nursing (DON) indicated the facility did not have a policy against posting isolation signs on resident's doors. The DON indicated she did not realize an isolation sign had not been posted on Resident #111's door.	F 441		

1X

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

PRINTED: 08/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING I B. WING _____		(X3) DATE SURVEY COMPLETED 08/06/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: A. Based on observation on 08/06/2013 the following doors failed to latch when closed, 207, 212, 309 and 312. 42 CFR 483.70 (a)</p>	K 018	<p>Disclaimer Statement:</p> <p>Tower Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Tower Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tower Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p>		
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or</p>	K 029	<p><u>K 018</u> Doors 207, 212, 309, and 312 were corrected by Maintenance Director on 8/21/13.</p> <p>A 100% audit was completed by Maintenance Director, Maintenance assistant, and Administrator to ensure that all doors are latching.</p>	8/23/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Administrator

(X6) DATE

8/23/13

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.



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

PRINTED: 08/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING I B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1 field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 08/06/2013 the dry storage room in the kitchen did not a closer on it. 42 CFR 483.70 (a)	K 029	Maintenance Director and Assistant will monitor doors latching using the audit tool three times a week for four weeks. QI committee will review audits every quarter to assure continued compliance. K 029 Door closures were ordered by Administrator on 8/7/13 and were placed on dry storage door, supply room door, and door to 111 by the Maintenance Director on 8/21/13. 100% audit of rooms requiring door closures was completed by Maintenance Director, Maintenance Assistant, and Administrator on 8/22/13. Maintenance Director and Assistant will monitor doors latching using the audit tool three times a week for four weeks. QI committee will review audits every quarter to assure continued compliance.	8/23/13

↓
BPAS 973033

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

PRINTED: 08/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING II B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: A. Based on observation on 08/06/2013 the door to room 600 failed to latch. 42 CFR 483.70 (a)	K 018	<u>K 018</u> Door 600 was corrected by Maintenance Director on 8/21/13. A 100% audit was completed by Maintenance Director, Maintenance assistant, and Administrator to ensure that all doors are latching. Maintenance Director and Assistant will monitor doors latching using the audit tool three times a week for four weeks. QI committee will review audits every quarter to assure continued compliance.	8/23/13
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed	K 029	<u>K 029</u> The 600 gate was corrected by the Maintenance Director on 8/7/13. 100% audit of gates/fences was completed by Maintenance Director, Maintenance Assistant, and Administrator on 8/22/13. Maintenance Director and Assistant will monitor gates/fences using the audit tool three times a week for four weeks. QI committee will review audits every quarter to assure continued compliance.	8/23/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

M. McHugh

TITLE

Administrator

(X8) DATE

8/23/13

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.

CP

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

PRINTED: 08/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING II B. WING _____		(X3) DATE SURVEY COMPLETED 08/06/2013
NAME OF PROVIDER OR SUPPLIER TOWER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3609 BOND STREET RALEIGH, NC 27604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 029	Continued From page 1 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029			
K 038 SS=D	This STANDARD is not met as evidenced by: A. Based on observation on 08/06/2013 the doors the Central Storage Room and room 111 (combustables stored in both rooms) across the hall failed to close and latch. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 08/06/2013 the delayed egress lock failed to unlock when pressure was applied. Some time the alarm did not sound and the door did not unlock and some time the alarm would sound and the door would unlock.. 42 CFR 483.70 (a)	K 038	<u>K 038</u> The entrance and exit door system on station 2 will be corrected on 8/28/13 100% audit of entrance and exit doors was completed by Maintenance Director on 8/21/13. Maintenance director and maintenance assistant will monitor door system by using the audit tool for three times a week for four weeks. QI committee will review audits every quarter to assure continued compliance.	8/28/13	