STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 03/04/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		3/31/17

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

Electronically Signed | 03/24/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 03/04/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on medical record review, family and staff interview it was determined that the facility failed to notify a family member of a new medication order for 1of 1 resident reviewed (Resident #1). Findings included: Per review of the significant change Minimum Data Set Assessment (MDS) dated 11/11/16, Resident #1 was admitted to the facility on 7/13/12. Her cognition was assessed as severely impaired. She was also coded as having continuous inattention and disorganized thinking Per review of physician orders Resident #1 was prescribed Lithium 200 milligrams (mg) by mouth at night for hallucinations and shouting on 12/12/16. The Geriatric Neuropsychiatry Service Note 12/16/16 stated the resident had diagnoses of dementia with behaviors and schizophrenia. The progress note written by the nurse practitioner stated, "Lithium was discontinued during hospitalization because of sedation secondary to infection. On return, Lithium continued to be held due to sedation. However, over the last month she has become more alert, and subsequently more agitated. On today's visit, she is seen	F 157	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 residents. The Plan of Correction is submitted as a written allegation of compliance. Tower Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tower Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. 1) Resident #1 responsible party was notified of medication in care meeting on 2/23/17. This is documented on grievance as resident out of facility at time of meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 03/04/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 self-propelling her wheelchair down the hallway singing nonsense rap songs at the top of lungs. 12/15/16 at 2:47: Resident in bed, Alert unable to assess orientation, patient talk out loud assimilating conversation with individual not present throughout night, confusion noted patient behavior appeared uncontrolled. Will resume HS (bed time) Lithium 200 mg, as this is what was successful in managing these behaviors in the past." Medical record review revealed Resident #1 was readmitted to the facility on 3/3/17 following a hospital stay with diagnoses which included type II diabetes, history of schizophrenia, dementia and stroke. Per interview with the resident's responsible party on 3/4/17 at 1:52 PM Resident #1 was taken off Lithium in October of 2016. He stated that he found out she was taking Lithium when the resident went to the hospital. Per record review the resident was admitted to the hospital on 2/19/17. He said that the resident could not make decisions for herself and he should have been included in the decision to put her back on the medication. Per the responsible party Resident #1 would get agitated if she did not want to be bothered and he was concerned that the facility was giving her the medication because they did not want to be bothered. He stated that he did not notice if the resident was sedated because when he came to visit in the afternoon she was awake. He stated he became concerned because facility staff was not getting her up. Interview with Nurse #1 at 2:28 PM 3/4/17 revealed that the nurse informs the responsible party when there is a new order. She stated that	F 157	2) 100% audit of all current residents' progress notes and physician orders for the past three months was completed on 3-17-17, to include resident #1, to ensure that RP was notified of any resident identified with a change in condition or treatment, to include medication changes. This audit was conducted by the DON, ADON, Consultant Nurse and Nurse Supervisors utilizing the Acute Change in Condition QI Tool. Any resident with a change that did not have documentation in the medical record of notification to the RP, the RP was contacted to discuss the changes and documentation of the follow up placed in the medical record. All calls, with RP notification or messages left for return calls were completed by 3-20-17, by the Administrator, DON, or ADON. 100% of all licensed nurses will be inserviced to ensure all responsible parties are updated timely with any change in condition or treatment, to include medications, and to ensure the notification is documented in the resident's medical record will be completed by 3/31/17. All new hired licensed nurses will be inserviced to ensure all responsible parties are notified timely with any change in condition or treatment, to include medications, and to ensure the notification is documented in the resident's medical record on orientation by the Staff Facilitator. 3) 100% of current resident's, to include resident #1, will be reviewed for change in condition or treatment using the 24 hour reports, MD orders and progress notes for RP notification by the DON, ADON, Nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 03/04/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3 sometimes she would see the nurse practitioner notify the family member but typically the nurse notified the family of new orders. Interview with the Director or Nurses at 3:30 PM on 3/4/17 revealed that she did not see information in the medical record indicating that the responsible party had been notified of the medication change.	F 157	Supervisor, QI Nurse and Staff Facilitator 5 days a week for 4 weeks, then weekly for 4 weeks, then monthly x 1 month utilizing an Acute Change in Condition QI Tool and addressing any areas of concerns at that time. The DON will review and initial the Acute Change in Condition QI Tool to ensure all areas of concerns were addressed weekly x 8 weeks and monthly x 1 month. 4) The Executive QI Committee will meet monthly and review Acute Change in Condition QI Tool and address any issues, concerns and/or trends and to makes changes as needed, to include continued frequency of monitoring x 3 months.	