AUG 2 4 2012->

PRINTED: 08/13/2012 FORM APPROVED OMB NO 0938-0391

		WILDIOAID SLIVIOLS				[7. 0930-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			B. WIN	lG		•	C	
		345051				08/0	3/2012	
	OVIDER OR SUPPLIER OMMUNITY HOSPITAL S	NF ·		5	REET ADDRESS, CITY, STATE, ZIP CODE 500 MORVEN RO NADESBORO, NC 28170	e4 a		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOIL TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		LD BE	(X5) COMPLETION DATE		
F 156 SS=B	RIGHTS, RULES, SE The facility must infor and in writing in a lan understands of his or regulations governing responsibilities during facility must also provinotice (if any) of the S §1919(e)(6) of the Acmade prior to or upon resident's stay. Receany amendments to it writing. The facility must inforentitled to Medicaid bof admission to the nuresident becomes eligitems and services under which the resident material the items and services the amount of charge inform each resident the items and service (i)(A) and (B) of this services under the time of admission to the resident of the resident of charges inform each resident the items and service (i)(A) and (B) of this services under Medicare or by under Medicare or by	m the resident both orally guage that the resident her rights and all rules and resident conduct and the stay in the facility. The ide the resident with the state developed under to Such notification must be admission and during the ipt of such information, and to must be acknowledged in the each resident who is enefits, in writing, at the time training facility or, when the public for Medicaid of the eat are included in nursing the State plan and for any not be charged; those cest that the facility offers dent may be charged, and is for those services; and when changes are made to see specified in paragraphs (5) ection. In each resident before, or on, and periodically during services available in the for those services, is for services not covered the facility's per diem rate.	F	156		received 0123 ential to be ve been CMS d will be og has ent name, n, and l be et when a f Nursing on a oring will ce and or a me	8/29/12	
					<u> </u>			

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

TITLE

(X6) DATE

Prosident

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

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	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(x3) DATE SURVEY COMPLETED C	
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		345051	B. WIN	<u> </u>		08	/03/2012
	OVIDER OR SUPPLIER OMMUNITY HOSPITAL S	BNF		500 !	T ADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170		
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F 156	Continued From page	e 1	F	156			!
	· -	nanner of protecting personal					:
	for establishing eligib	equirements and procedures illty for Medicaid, including n assessment under section	:	: : : :			
	1924(c) which determ non-exempt resource	nines the extent of a couple's as at the time of		1			
	spouse an equitable cannot be considered	d attributes to the community share of resources which d available for payment		1 : :			
	•	e institutionalized spouse's r her process of spending gibility levels.		:			
	numbers of all pertine groups such as the S agency, the State lice ombudsman program advocacy network, are unit; and a statement complaint with the St agency concerning remisappropriation of reference such as the statement agency concerning remisappropriation of reference such as the statement agency concerning remisappropriation of reference such as the statement agency concerning remisappropriation of reference such as the statement agency concerning remisappropriation of reference such as the statement agency ag	nd the Medicaid fraud control that the resident may file a ate survey and certification esident abuse, neglect, and esident property in the pliance with the advance					
	specified in subpart I related to maintaining procedures regarding requirements include provide written inform concerning the right to r surgical treatment option, formulate an	oply with the requirements of part 489 of this chapter g written policies and g advance directives. These provisions to inform and nation to all adult residents to accept or refuse medical and, at the individual's advance directive. This scription of the facility's				·	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345051	B. WN	G		08	3/03/2012	
	OVIDER OR SUPPLIER	SNF		500 N	ADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 156	The facility must informame, specialty, and physician responsib The facility must prowritten information, applicants for admission.	at advance directives and brown each resident of the did way of contacting the did for his or her care. whinently display in the facility and provide to residents and	F	156				
	receive refunds for particles and benefits. This REQUIREMENT by: Based on record refacility failed to inclure questing an immed Medicare non-cover (Residents #19 and 1. Review of the "Non-Coverage" form 7/5/12, revealed as	n for Resident #73, dated ection entitled "How to Ask for al." One of the steps read,						
	Organization] at: {ii number of QIO} to a questions." During an interview business office empindicated that they j	on 8/3/12 at 10:35 AM, the sloyee who issued the Notice ust recently started using this she did not realize that the						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		08/03	/2012
	OVIDER OR SUPPLIER OMMUNITY HOSPITAL	BNF	50	EET ADDRESS, CITY, STATE, ZIP CODE 00 MORVEN RD VADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 156	2. Review of the "No	tice of Medicare	F 156			
F 279 SS=J	7/15/12, revealed a set for an Immediate Ap "Call your QIO [Qual Organization] at: {in number of QIO} to a questions." During an interview business office empindicated that they juparticular form and set QIO information was 483.20(d), 483.20(k) COMPREHENSIVE A facility must use the to develop, review a comprehensive plan. The facility must deplan for each reside objectives and timel medical, nursing, an needs that are identicals assessment. The care plan must to be furnished to all highest practicable.	sert QIO name and toll-free ppeal, of if you have on 8/3/12 at 10:35 AM, the loyee who issued the Notice last recently started using this she did not realize that the sont included. In Interview of the assessment and revise the resident's a of care. In It includes measurable ables to meet a resident's and mental and psychosocial diffied in the comprehensive describe the services that are train or maintain the resident's physical, mental, and	F 279	F 279 On August 2, 2012, Resident #68 was to an acute care facility for evaluation seizure and was subsequently admitter #68 did not return to the facility and can in-patient hospice facility. Because all residents with behaviors he potential to be affected by the cited de medical records and care plans (52 tot residents with documented behaviors reviewed by Administrator, Director of and (3) RN Supervisors on August 2, assure appropriate behavior interventing place. No additional residents with unbehaviors were identified during the residents.	following a d. Resident urrently is in have the efficiency, the hal) for were for Nursing 2012 to ons were in addressed	
	§483.25; and any some be required under § due to the resident's	eing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under he right to refuse treatment).				

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETION DATE
4	F 279	F 279		
ew, observation and staff alled to develop a care plan is and interventions to a for 1 (Resident #68) of 2 in known self injurious ad bitten her fingers causing to be necrotic and infected. dy (IJ) for Resident #68 2 when the fingers were e administrator was notified ardy (IJ) on August 2, 2012 as removed on August 3, the Credible Allegation was a interview and record is left out of compliance at e potential for more than of IJ (D) to allow alloyee training. mitted to the facility on diagnoses including Bipolar frive on Feeding Tube, at status post cerebral m Data Set (MDS) 108/12 indicated that behavioral symptoms.		Data Set (MDS) Coordinator was a additional education by the Post A Services Director of Quality Mana on August 3, 2012. Education included in the Post A Services Director of Quality Mana on August 3, 2012. Education included in the MDS Coordinator research and family in the development. In the MDS Coordinator reseducated Interdisciplinary Team on August Additional education was provided team regarding Resident Behavior Interventions offered by the License Psychologist on August 6, 2012 and 7, 2012. On-going systemic change include; on a daily basis, the Chargwill document any changes in behatine 24 hour report, which will be reby the RN Supervisor. Performance will be monitored by Acuity Intervention Team, which of the Administrator, Director of Nur RN Supervisors, MDS Coordinato Social Work, Admissions Coordin Therapy will, on a weekly basis, as medical records to assure that approbehavioral interventions, assessme care planning are in place. Results monitoring will be shared with the of Nursing weekly and with the facuality Assurance/Process Improv (QAPI) Committee monthly. Monivill continue for a minimum of ninat which time frequency of monito	provided cute Care gement uded ations, to f staff to turn, the 3, 2012. If to the and sed d August tes ge Nurse avior on eviewed the consists of sing, 3 r, Dietary, ator and udit five copriate and of this Director cility ement atoring nety days ring will	8/29/12
	IDENTIFICATION NUMBER:	A BUILDING 345051 STREE STREENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) A F 279 Is not met as evidenced ew, observation and staff ailed to develop a care plan is and interventions to is for 1 (Resident #68) of 2 in known self injurious ad bitten her fingers causing to be necrotic and infected. A BUILDING B. WING PREFIX TAG F 279 Is not met as evidenced ew, observation and staff ailed to develop a care plan is and interventions to is for 1 (Resident #68) of 2 in known self injurious ad bitten her fingers causing to be necrotic and infected. Add (IJ) for Resident # 68 2 when the fingers were to administrator was notified ardy (IJ) on August 2, 2012 as removed on August 3, the Credible Allegation was finterview and record is left out of compliance at the potential for more than tot IJ (D) to allow bloyee training. Initted to the facility on diagnoses including Bipolar for the facility on	IDENTIFICATION NUMBER: 345051 A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 500 MORVEN RD WADESBORO, NC 28170 PROVIDER'S PLAN OF CORRECT GEAR CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION OF THE APPROPRIATION F 279 F 279 To address systemic changes the N Data Set (MDS) Coordinator was a additional education by the Post A Services Director of Quality Mana on August 3, 2012. Education incl review of care plan development, individualization of goals, interver updating procedures, and inclusion and family in the development. In the MDS Coordinator re-educated Interdisciplinary Team on August Additional education was provided the MDS Coordinator re-educated Interdisciplinary Team on August Additional education of goals, interver updating procedures, and inclusion In the MDS Coordinator re-educated Interdisciplinary Team on August Additional education was provided the MDS Coordinator re-educated Interdisciplinary Team on August Additional education was provided the MDS Coordinator re-educated Interdisciplinary Team on August Additional education was provided the MDS Coordinator re-educated Interdisciplinary Team on August Additional education was provided the MDS Coordinator re-educated Interdisciplinary Team on August Additional education was provided the MDS Coordinator re-educated Interdisciplinary Team on August Additional education was provided the MDS Coordinator re-educated Interdisciplinary Team on August Additional education was provided the MDS Coordinator re-educated Interdisciplinary Team on August Additional education was provided the MDS Coordinator re-educated Interdisciplinary Team on August Additional education was provided the MDS Coordinator re-educated Interdisciplinary Team on August Additional education was provided team regarding Resident Behavior Interventions of Freed by the Licen Psychologist on August 6, 2012 and Additional education was provided team regarding Resident Behavior Interventions of Freed by the Licen Psychologist on August	TOMPLET ABJORNS 345051 STREET ADDRESS, CITY, STATE, ZIP CODE 500 MORVEN RD WADESBORO, NC 28170 PROMDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 4 F 279 F 279 To address systemic changes the Minimum Data Set (MDS) Coordinator was provided additional education by the Post Acute Care Services Director of Quality Management on August 3, 2012. Education included review of care plan development, individualization of goals, interventions, updating procedures, and inclusion of staff and family in the development. In turn, the MDS Coordinator re-educated the Interdisciplinary Team on August 3, 2012. Additional education was provided additional education was provided additional education staff and family in the development. In turn, the MDS Coordinator re-educated the Interdisciplinary Team on August 3, 2012. Additional education was provided to the team regarding Resident Behavior and Interventions offered by the Licensed Psychologist on August 6, 2012 and August 7, 2012. On-going systemic changes include; on a daily basis, the Charge Nurse will document any changes in behavior on the 24 hour report, which will be reviewed by the RN Supervisors, MDS Coordinator pad Therapp will, on a weekly basis, audit five medical records to assure that appropriate behavioral interventions, assessment and care planning are in place. Results of this monitoring will be shared with the Director of Nursing weekly and with

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ILTIPLE C	CONSTRUCTION	(X3) DATE SU	
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F 279		ers on the right and left hip.	F:	279			
	when the wound vac 07/16/12, the hand m prevent self injury, re	discontinued on 06/04/12 was discontinued. On hitten was restarted to moval of dressing, foley	:				
. !	Resident #68 had be directed toward other as hitting or scratchir public sexual acts, di smearing food or boo symptoms like screat	ge in status MDS 4/19/12 indicated that havioral symptoms not rs (physical symptoms such ng self, pacing, rummaging, isrobing in public, throwing or dily wastes or verbal/vocal ming, disruptive sounds) lays but less than daily					
	Assessments (CAAs dated 04/19/12 reveal year old who triggered assessment due to dhitting herself with so rails. She has recenfrom hospice. She hidepression and anxieticerebrovascular accidental dates of the depression and anxietic dates of the depression and depression and depression and depression and dates of the depression and d) for behavioral symptoms aled " resident is a (age) ed for a behavioral lisplaying behavior such as oft mitten and shaking side tly started receiving services has a diagnosis of bipolar, ety. She also has a history of ident (CVA) and seizures.					
	currently going to the a major change in he returned back to the good. Resident is he The assessment also another discipline was	chaviors when she was be wound center. Staff noticed be behavior when she facility. Her family support is bere for long term placement. " to indicated that referral to be not warranted and care bed to monitor resident's s.					
		04/25/12 was reviewed. The ras " name of the resident)		į			

F 279 Continued From page 6 needs monitoring of mood (crying/tearfulness, repetitive verbalizations, anxiousness, sad/anxious appearance) and behaviors (yelling/screaming out, resistive with care) associated with bipolar disorder requiring the use of multiple psychotropic medications. " The goal was " mood and behaviors will be better controlled while on psychotropic medications as evidenced by decreased episodes of anxiety/restlessness and decreased episodes of yelling/screaming out weekly over the next review." The approaches included " monitor resident's mood and behavior status daily (e.g resistive with care, repetitive verbalizations, crying/tearfulness, etc.) on behavior flow sheet and or in notes. Notify physician of any increased behaviors or mood, administer Paxil (anti-depressant)as ordered, administer Geodon as ordered routinely for the treatment of bipolar disorder, administer xanax (anti-anxiety), provide reassurance and comfort when she appears to be upset, encourage her to express/ventilate feelings, explain all procedures prior to rendering	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
ANSON COMMUNITY HOSPITAL SNF CAN ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			345051	B. WING					
F 279 Continued From page 6 needs monitoring of mood (crying/tearfulness, repetitive verbalizations, anxiousness, sad/anxious appearance) and behaviors (yelling/screaming out, resistive with care) associated with bipolar disorder requiring the use of multiple psychotropic medications. "The goal was "mood and behaviors will be better controlled while on psychotropic medications as evidenced by decreased episodes of anxiety/restlessness and decreased episodes of yelling/screaming out weekly over the next review." The approaches included "monitor resident's mood and behavior status daily (e.g resistive with care, repetitive verbalizations, crying/tearfulness, etc.) on behavior flow sheet and or in notes. Notify physician of any increased behaviors or mood, administer Paxil (anti-depressant)as ordered, administer Geodon as ordered routinely for the treatment of bipolar disorder, administer xanax (anti-anxiety), provide reassurance and comfort when she appears to be upset, encourage her to express/ventilate feelings, explain all procedures prior to rendering			BNF	500 MORVEN RD					
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care to help decrease chance of combativeness and or anxiety, encourage family visit, assist out of room activities for socialization and hospice services per their plan of care. " Resident #68 was on psychoactive medications to control her behaviors. The physician's order for June, 2012 indicated that Resident #68 was on Valium 5 mgs 1 tablet daily for anxiety disorder, Geodon 40 mgs daily for bipolar disorder and Ativan 1 mgs every 8 hours for anxiety disorder. The nurse's notes were reviewed. The notes dated 06/02/12 at 7:30 AM, revealed that	F 279	needs monitoring of repetitive verbalization sad/anxious appeara (yelling/screaming out associated with bipol of multiple psychotron was "mood and bedecontrolled while on previdenced by decreat anxiety/restlessness yelling/screaming out review." The approtesident's mood and resistive with care, recrying/tearfulness, et and or in notes. Noti behaviors or mood, at (anti-depressant) as ordered routinely disorder, administer are reassurance and contupset, encourage her feelings, explain all procare to help decrease and or anxiety, encourage her feelings, explain all procare to help decrease and or anxiety, encourage her feelings, explain all procare to help decrease and or anxiety, encourage her feelings, explain all procare to help decrease and or anxiety, encourage her feelings, explain all procare to help decrease and or anxiety, encourage her feelings, explain all procare to help decrease and or anxiety disorder and Ativan 1 disorder, Geodon 40 disorder and Ativan 1 anxiety disorder. The nurse's notes we are repetitive verbalization.	mood (crying/tearfulness, ons, anxiousness, once) and behaviors at, resistive with care) ar disorder requiring the use pic medications. " The goal haviors will be better sychotropic medications as sed episodes of and decreased episodes of and decreased episodes of tweekly over the next aches included "monitor behavior status daily (e.g. apetitive verbalizations, c.) on behavior flow sheet fy physician of any increased administer Paxil ordered, administer Geodon for the treatment of bipolar scanax (anti-anxiety), provide an fort when she appears to be a to express/ventilate arocedures prior to rendering the chance of combativeness arage family visit, assist out socialization and hospice of care. " In psychoactive medications order ted that Resident #68 was ablet daily for anxiety mgs daily for bipolar are reviewed. The notes	F	279				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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F 279	trying to remove the last of blood was noted or mitten was removed a with warm water, cuts and posterior area of were no changes manaddress the self injuriat 1:45 PM, the MDS interviewed. She stat changes to the care paware of the 06/02/12 #68 had bitten her find the control of the control	ing her right index finger hand mitten. A small amount in the mitten. After the hand and the finger was cleaned is were noted on the dorsal the index finger. There do to the care plan to fous behavior. On 08/02/12 foare plan nurse was ted that she did not make plan because she was not to incident when Resident gers. AM, the nurse's notes and #68 was in bed, she had she neck, chest and arms. Aft, resident had self inflicted by. On 07/08/12 at 10:30 to have multiple areas of ad left arm, resident was self with right hand and symptoms of agitation. The smade to the care plan to the from repeated self injurious and vac and the hand mitten there was no doctor's order and mitten, it was per the stration.	F 279					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345051	B. WING				3/2012
NAME OF PR	OVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
ANSON C	OMMUNITY HOSPITAL S	NF			MORVEN RD		
				WA	ADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	smearing food or bod symptoms like screar which occurred 1-3 did the nurse's notes on revealed that the resibleeding coming from chewing on hand. Lar mouth, face and cloth notes further indicate physician was notified to the emergency roo #68 was back to the froom. On 07/16/12 a indicated that an order of untied mitten. Res	srobing in public, throwing or ily wastes or verbal/vocal ning, disruptive sounds) ays during the review period. 07/14/12 at 5:35 AM dent was found with profuse the right hand related to ge amount of blood in the ling was observed. The did that the attending did and the resident was sent m. At 7:45 AM, Resident acility from the emergency to 11:30 AM, the notes are was written to clarify use ident has harmed self over	F2	779			
		ring on hand. She had removing fully inflated foley, I dressing to wound.		:			
	were reviewed. The chief complaint was 'patient found chewing On physical examinat to have deep abrasio The clinical impression abrasions right hand notes further revealed.	records dated 07/14/12 notes revealed under the bleeding fingers right hand, g flesh from hand by staff. " cion, the resident was noted as on right hand fingers. In was self inflicted from patient biting. The multiple wounds on right hewing on first 2 fingers and					
	mitten (untied) to righ removal of dressing,	as a doctor's order to wear t hand to prevent self injury, foley catheter, and g-tube, provide care, monitor					

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F 279	Continued From pa	age 9	F 279			
	prevent self injurior plan problem. On to aide with agitatic approaches. There care plan to prever happening again a mitten. The care plan date reviewed. The care (name of resident) prevent her from so of resident) needs (crying/tearfulness anxious complaints behaviors (yelling/scare, self abusive a bipolar disorder recipsychotropic medication thave a measur address the care a injurious behavior at 1:45 PM, the MI interviewed. She will be prevent her from somood/behavior and medication care plashe did not develo approaches specif She added that Reto prevent her from medications were approached to prevent her from medications were all the prevent her from the prevent her f	tilization of the hand mitten to us acts was added to the care 07/17/12, " ativan as ordered on " was added to the were no changes made to the at the self injurious acts from side from Ativan and hand d 07/18/12 (review date) was a plan problems included " utilizes a hand mitten to elf injurious acts and " (name monitoring of mood a repetitive verbalizations, a, sad/anxious appearance and acreaming out, resistive with acts, etc.) associated with quiring the use of multiple cations. " The care plan did able goal and interventions to and treatment related to the self of Resident #68. On 08/02/12 DS/care plan nurse was was aware of the incident when chewed her fingers on ated the care plan on 07/18/12 e use of the hand mitten to elf injurious acts to the d use of psychotropic an problem. She indicated that p a care plan with goals and ict to the self injurious behavior, esident #68 was on hand mitten in self injurious acts and her adjusted after the 07/14/12				
	incident.					1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVI COMPLETED	
		345051	B. WING		C 08/03/2012	
	ROVIDER OR SUPPLIER	NF	5	REET ADDRESS, CITY, STATE, ZIP CODE 500 MORVEN RD WADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	hand of Resident #68 observed to be necro. The wound had yello was macerated. Nur the fingers with Betadand covered with dry. On 08/01/12 at 10:15 interviewed. She ind socks were tried for from biting her finger. On 08/01/12 at 11:20 was interviewed. She of the 2 incidents who chewed her fingers. not tried other measumitten to prevent her. On 08/01/12 at 3:40 interviewed. She stat physician when he sat 07/30/12. She found with slough tissue an The physician had or debridement of the rich on 08/01/12 at 5:05 interviewed. She stat 07/28/12 when she for index finger wounds. removed four maggo further stated that ha tried to prevent her from the finger wounds.	AM, Nurse # 11 was dressing change to the right b. The right index finger was tic, swollen and with odor. wish wound bed. The thumb se #5 was observed to clean dine, xeroform was applied dressing. AM, Nurse #11 was dicated that hand mitten and desident #68 to prevent her s. AM, administrative staff #2 se stated that she was aware here Resident #68 had She indicated that she had res aside from a hand from biting her fingers. PM, Nurse #4 was ted that she was with the law Resident #68 on the finger to be macerated d with yellowish drainage, dered surgical consult for ght index finger.	F 279			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WNG			9
		345051	B. WING		08/0:	3/2012
	OVIDER OR SUPPLIER DMMUNITY HOSPITA	L SNF	500 N	ADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ION SHOULD BE COMPLETION THE APPROPRIATE DATE	
F 279	remove them. On 08/02/12 at 9:0 scheduled for debringer at the hospit facility after lunch. performed to the rethe hospital staff with the surgical staff with the surgical construction of the right index from the hard she could not were tried to prevent aside from the hard she could not were tried to prevent index from the hard she could not were tried to prevent index from the hard she could not were tried to prevent index from the hard she could not were tried to prevent in the right index from the hard she could not were tried to prevent in the right index from the hard she could not were tried to prevent in the right index from the hard she could not were tried to prevent in the right index from the hard she could not were tried to prevent in the right index from the hard she could not were tried to prevent in the right index from the hard she could not were tried to prevent in the right index from the right index	O AM, Resident #68 was idement of the right index al. She came back to the Debridement was not esident's finger. At 2:20 PM, as interviewed. She stated gical service supervisor who irgeon. She indicated that ensive tissue loss, not of benefit so the surgeon lent #68 to the orthopedic ion of the right index finger. Altation report dated 08/02/12 be report revealed examination inger. The debridement was enefit considering extensive immend treatment by surgeon and wound care. AM, the administrative staff d. She stated that Resident is hand mitten when she chewed 2/12. She indicated that the indered because she was vac, g-tube and foley catheter ed that when the wound vac the use hand mitten was restarted her fingers again. She added think of other measures that each her from biting her fingers	F 279			
	jeopardy on 08/02		:			! ! !

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					JRVEY TED
		345051	B. WIN	G		08/	C 03/2012
	OVIDER OR SUPPLIER DMMUNITY HOSPITAL S	NF	•	500	T ADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 279	Continued From page	12	F	279			
	The facility provided a compliance on 08/03/	credible allegation of 12 at 7:08 PM.					
	The allegation of com	pliance indicated:	i :				
	· On August 3, 2012, transferred to (name a medical issues. Follow	of the hospital) for unrelated					
	Resident #68 will be t	ransferred to Hospice medications, and very	:				
	Status, & seizure disc	ge, severe Altered Mental order, long history of rash, order, & multiple infections.	:				:: -: -: ::
	Hospice House was r	ecommended by (name of dical Officer for (name of the	: !				
		ol seizures & behaviors.	!				
	potential to be affecte medical records (52 to residents with docume re-evaluated by Admir						
	were in place. No ad-	priate behavior interventions ditional residents with rs were identified during the					
	(name of the manage Care Director of Qual MDS Coordinator edu (interdisciplinary team Education included ca) on August 3, 2012.					

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONS	STRUCTION	(X3) DATE SU COMPLE	
		345051	B. WNG	_		08/	C 03/2012
	OMMUNITY HOSPITAL S	NF	STREET ADDRESS, CITY, STATE, ZIP CODE 500 MORVEN RD WADESBORO, NC 28170				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	updating procedures, participate in educati intervention offered be on August 6, 2012 or . The Acuity Interventhe Administrator, Discordinator, & Thera audit five medical recappropriate intervent planning are in place reviewed weekly at the meeting to ensure the intervention, assessing place. Family and stare offered an oppor care plan process to care.	The team will also on resident behavior and by (name of the psychologist) August 7, 2012. tion Team, which consist of rector of Nursing, 3 RN Social Worker, Admissions upy, on a weekly basis, will	F 2	79			
	Director of Nursing v Quality Assurance a monthly. Monitoring ninety days at which and Assessment Co deficiency has been determined that the monitoring will be co Corrective Action Da The credible allegati 7:10 PM as evidenc review of the in-serv plan development, in interventions and ho	veekly and with the facility and Assessment Committee will continue a minimum of time the Quality Assurance mmittee will determine if the resolved. If it has been deficiency has been resolved, anducted on a quarterly basis.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345051	B. WNC			08/0:) 3/2012
	OVIDER OR SUPPLIER	BNF		500 F	TADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 279	had goals and interv behaviors.	ere reveiwed. The care plan entions in place for		279	E 202		
F 282 SS=D	282 483.20(k)(3)(ii) SERVICES BY QUALIFIED		F 2	282	F 282 Corrective action for Reside transferring resident to the a wheelchair with anti-tippers placement of fall mat next to Corrective action for Reside placement of Dycem in the wheelchair.	appropriate s with Dycem and o the resident's bed. ent #101 included;	
					Because all residents with f have the potential to be affe deficiency, all residents ide safety devices/interventions and corresponding care plan assure inclusion of safety de	ected by the cited ntified as requiring to prevent falls and as were reviewed to evices/interventions.	
	facility 11/21/08. Cu Seizure disorder, De Joint Disease. A Quarterly Minimun assessment dated 7, #11 was moderately	s originally admitted to the mulative diagnoses included mentia and Degenerative n Data Set (MDS) /13/12 indicated Resident impaired in cognition. the fall without injury and one			Systemic changes include re nursing staff by the Directo assure devices/interventions maintained as indicated in t care. This education will be the facility education progra hire and annually. A nurse assess the resident after a fa corrective/preventive action will be conducted by the In- Team the next business day	r of Nursing to s to prevent falls are he resident's plan of incorporated into am at the time of will immediately all and implement a. A post fall review terdisciplinary to determine if the	
	fall with injury (except assessment done or A Care plan reviewe problem of potential impaired mobility, his psychotropic medical problems. The goal in o injury as a result	ot major injury) since the last 1 4/19/12. Id on 7/18/12 included a for falls secondary to			appropriate prevention strate and to update the care plan. Audits will be conducted by Administration weekly on a residents with care planned. Audits to include resident of care planned interventions a will be reported to the Administration and to the Q Process Improvement(QAP monthly for 90 days at white of monitoring will be determined.	if needed. y Nursing a random sample of falls interventions. bservation to assure are in place. Results inistrator on uality Assurance/ I) Committee ch time frequency	8/29/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	345051	B. WNG		08/03/2012		
NAME OF PROVIDER OR SUPPLIER ANSON COMMUNITY HOSPITAL	. SNF	STREET ADDRESS, CITY, STATE, ZIP CO 500 MORVEN RD WADESBORO, NC 28170				
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
injury from falls from wheelchair for safet wheelchair." An observation on a Resident #11 lying was not a fall mat of the floor. On 8/2/12 at 8:00 A Resident #11's room a fall mat on the floom she expected that a in place which inclusion. On 8/2/12 at 9:49 A observed sitting in The wheelchair did was a Dycem pad incontinent pad on On 8/2/12at 9:58Aff assistant had place wheelchair and she wheelchair with the interview, she instructive, she instructive, she instructive, she instructive, she instructive wheelchair in the resident #11 back correct wheelchair. On 8/2/12 at 10 Affective wheelchair in the resident in the room the red Dycem was wheelchair belonge interview, NA # 2 final resident in the room the red Dycem was wheelchair belonge interview, NA # 2 final resident in the resident in the room the red Dycem was wheelchair belonge interview, NA # 2 final resident in the resident in the room the red Dycem was wheelchair belonge interview, NA # 2 final resident in the resident in the room the red Dycem was wheelchair belonge interview, NA # 2 final resident in the resident in the room the red Dycem was wheelchair belonge interview, NA # 2 final resident in the resident in the room the red Dycem was wheelchair belonge interview, NA # 2 final resident in the resident in t	at to help reduce the risk of m the bed. Antitippers to the by. Dycem (a non-slip pad) to be and noted in her room. There on the floor beside the bed. AM., Nurse #1 went to m and noted that there was not not beside the bed. She stated all interventions for falls to be added a fall mat to be on the by. Dycem and have antitippers. There in the wheelchair with a cloth top of the Dycem. M., Nurse #1 stated the nursing a Resident #11 in the wrong a should have been in the cantitippers. During the ucted nursing staff to take to her room and put her in the	F 282				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL	
		345051	B. WNG		OF	C 3/03/2012
	ROVIDER OR SUPPLIER	L SNF	600	ET ADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 282	around 8:00 AM. On 8/2/12 at 2:13 I stated she expected interventions for fall included the fall may wheelchair and Dy. 2. Resident #101 v. 12/25/11. Diagnose Parkinson 's disease. The most recent qu. 5/4/12, revealed the with no major injury assessment. Resident #101's call included a problem to requiring assistate falls, unsteady gailt of restless behavior a result of a fall at Approaches included wheelchair to prevent to prevent to the prevent of the prevent o	PM., Administrative staff #2 ad nursing staff to use all of the alls for Resident #11 which at, antitippers on the cem. vas readmitted to the facility on es included dementia and ase. uarterly assessment, dated at Resident #101 had 1 fall	F 282			

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345051	A. BUILDING B. WING		08/0	C 03/2012
	ROVIDER OR SUPPLIER	SNF	500 1	T ADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	expect the Dycem to as care planned. 483.25(d) NO CATHRESTORE BLADDE Based on the reside assessment, the factor individual catheter resident's clinical control catheterization was who is incontinent of treatment and service infections and to resident's clinical control catheterization was who is incontinent of treatment and service infections and to resident and service function as possible. This REQUIREMENT by: Based on observate facility failed to seep prevent excessive to failed to keep the untouching the floor for residents with urinate Findings included: Resident # 92 was Cumulative diagnost hypertrophy (BPH), hematuria (blood in An Annual Minimum dated 5/31/12 indicater memory impairmed in decision in the service of the plant	e #2 indicated she would be in Resident #101's chair HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a the facility without an is not catheterized unless the andition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder existed a urinary catheter to ension on the catheter and rinary catheter tubing from or one of two sampled any catheters (Resident # 92).	F 315	Immediate corrective action fo #92 included properly securing catheter and placing off the flo Because all residents with urin have the potential to be affecte same deficient practice, all resurinary catheters were evaluate that tubing was appropriately scatheter bag was positioned of Systemic changes included, all staff including nursing assistance-ducated by the Director of Infection Preventionist regardiprevention of urinary tract infeemphasis on proper care and purinary catheters. Positioning included, maintaining off the fof catheter bag for resident's with chair and in bed. The Infection Preventionist with compliance on a weekly basis document on the established lewill be reported to the Adminimately and to the Quality Ass Process Improvement Commitmentally basis for a minimum days at which time frequency will be determined.	ary catheters d by the idents with ed to assure secured and f the floor. I nursing its was Nursing and ing ections with ositioning of education cloor position while in wheel Ill monitor and og. Results strator urance and ttee on a of ninety	8/29/12

	DE DESICIENCIES			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	I ' '	LDING	CONDITIONION	COMPLI		
			B. WIN		to the state of th		С	
		345051	O. VVIIV			08.	03/2012	
	ROVIDER OR SUPPLIER OMMUNITY HOSPITAL S	SNF		500 (T ADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170	,		
	· OUBLIANDY OF	PATCHENT OF DECOMENDICS	1 10	1	PROVIDER'S PLAN OF CORRECT	TION	rve.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 315	Continued From page	e 18		315				
	personal hygiene and	d bathing. Resident # 92 had		0.0				
	an indwelling urinary	catheter.						
	1	1/12 at 3:49 PM. revealed		1				
	1	wheelchair in the dining area.						
		ubing was hanging on the ainage bag was in a blue						
		g on the crossbars positioned						
	under the seat of his			İ				
	On 8/1/12 at 4:09 PM	1., Nurse # 7 stated the		İ				
		d be below the level of the						
		h the floor. She removed						
		he dining area and placed						
		tubing in the blue privacy						
	bag.							
	During the observation	on of urinary catheter care on						
		the urinary catheter tubing	i					
		Resident # 92's leg. Nurse #	:					
		catheter tubing should be th a secure care strap. She	i					
		Resident # 92 would pull at	!					
	the urinary catheter t	ubing and sometimes	!					
	removed the secure	care strap.	i	İ				
	On 8/2/12 at 1:51 PM	1., nursing assistant # 3	:					
		's urinary catheter tubing						
		en he provided ADL (activities			1			
		He stated he provided care			·		ļ	
		ce or twice a week and had ary catheter tubing until					1	
		he nursing staff told him to		:			i	
	secure the urinary tu			!			1	
	On 8/2/12 at 2:04 PM	1., Administrative staff #2		:			*	
		ibing should not have been		*			i	
	on the floor. Also, th	e catheter tubing should be					1	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245054	B. WIN			000	C
NAME OF BE	ROVIDER OR SUPPLIER	345051		erocc	T ADDRESS, CITY, STATE, ZIP CODE	08/	03/2012
	OMMUNITY HOSPITAL	BNF		500	MORVEN RD DESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 315 F 323 SS=J	secured unless other 483.25(h) FREE OF HAZARDS/SUPERV The facility must ens environment remains as is possible; and e	wise noted by physician. ACCIDENT		315	F 323 1. On August 2, 2012, Resider transferred to an acute care face evaluation following a seizure subsequently admitted. Resident return to the facility and cuan in-patient hospice facility. 2. Resident #11 was transferred appropriate wheelchair with an example of the series o	ility for and was ent #68 did arrently is in ed to the	
	by: Based on record revinterview, the facility interventions to previnjuries for 1 (Reside residents with known Resident #68 had biright index finger to facility also failed to prevent falls as care of 3 sampled resident. The immediate jeop began on June 2, 20 injured from biting. To fit in immediate jeon at 2:45 PM. The IJ 2012 at 7:15 PM aftivalidated through streview. The facility in actual harm with minimal harm that is completion of the er	T is not met as evidenced view, observation and staff failed to implement effective ent repeated self inflicted ent # 68) of 2 sampled a self injurious behavior. Itten her fingers causing the obe necrotic and infected. The implement interventions to planned for 1 (Resident #11) and the findings include ardy (IJ) for Resident # 68 and (IJ) for Resident # 68 and (IJ) on August 2, 2012 was removed on August 3, are the Credible Allegation was aff interview and record vas left out of compliance at the potential for more than a not IJ (D) to allow apployee training. Example #2 ited at no actual harm with			Dycem was also placed in whe falls mat next to the resident's 1. Because all residents with the have the potential to be affected cited deficiency, all medical resident and care plans for resident documented behaviors were resident documented behaviors were resident documented behaviors on Auton assure appropriate intervent place. In addition, inservice to resident behavior was conduct Licensed Psychologist on Augand August 7, 2012. This eduprogram was videotaped for an education purposes. Because with wounds have the potential affected by the cited deficience residents receiving wound treat evaluated by the Wound Care All wounds were found to be a signs or symptoms of infection	selchair and bed. sehaviors and by the cords (52) at with evaluated of Nursing gust 2, 2012 ions were in aining on eed by a sust 6, 2012 seational additional staff all residents all to be y, all attents were Coordinator.	

CENTER	S LOW MEDICAKE &	MICDICAID SERVICES				OMD MC	. 0830-0381
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		345051	B. WIN	1G _		08/0	3/2012
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
					500 MORVEN RD		
ANSON C	OMMUNITY HOSPITAL S	SNF			WADESBORO, NC 28170		
WA 15	TO VOMINIO	ATEMENT OF DEFICIENCIES	10	1	PROVIDER'S PLAN OF CORRECT	TION	NE.
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD 8E	(X5) COMPLETION DATE
F 323	Continued From page	⇒ 20	F	32	3 F323		
		than minimal harm that is			1323		
	not IJ (D).			Mandatory inservices for all nurs began on August 3, 2012. Educa identification and reporting of wo	tion included		
		admitted to the facility on			signs and symptoms of infection.		
	,	e diagnoses including Bipolar			inservices were conducted by the		
		hrive on Feeding Tube, nd status post cerebral			Administrator, the Director of Nu RN Supervisors.	irsing and the	
		erly Minimum Data Set			KIN Supervisors.		
		ated 03/08/12 indicated that			2. Because all residents with fall	S	
	, ,	behavioral symptoms. The	: :		interventions have the potential to		
		status MDS assessment			by the cited deficiency, all reside		
	dated 04/19/12 indica	ated that Resident #68 had			identified as requiring safety devi interventions to prevent falls were	ces/ e reviewed	
	behavioral symptoms	not directed toward others			to assure appropriate intervention		
		such as hitting or scratching			place as care planned.	:	
•		ing, public sexual acts,					
		rowing or smearing food or	!		1. Systemic changes to address b		
		al/vocal symptoms like			include assuring that appropriate are followed at the time a residen		
		sounds) which occurred 4-6			identified. Procedures include th		
		nily during the review period.			observing the behavior will be	'	
	The quarterly Minimu assessment dated 07	• •			responsible for the documentation		
		emory and decision making			hour report which will be reviewed Supervisor. The Acuity Intervent		
		havioral symptoms not			Team will review each resident so		
		s (physical symptoms such	:		interventions are maintained and	revised on a	
		g self, pacing, rummaging,	i		weekly basis. Education regardi		
		srobing in public, throwing or	į		behaviors will be incorporated in		
	·	lily wastes or verbal/vocal			employee and annual mandatory Systemic changes to address wou		
		ning, disruptive sounds)			at the time a wound is identified.		
	which occurred 1-3 d	ays during the review period.	1		report will be completed, immedi interventions implemented and do	ate	
	The care plan dated (07/18/12 was reviewed. The			The Wound Care Coordinator wi		
		icluded " (name of resident)			wounds on a weekly basis to assu	re appropriate	
		to prevent her from self			treatment/interventions are in pla	ce.	
		name of resident) needs					
	monitoring of mood (crying/tearfulness, repetitive					
		ıs complaints, sad/anxious					
		aviors (yelling/screaming					
	out, resistive with car	e, self abusive acts, etc.)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345051	B. WIN				C)3/2012
	OVIDER OR SUPPLIER	. SNF	•	500	ET ADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D 8E	(X5) COMPLETION DATE
F 323	of multiple psychotoplan did not have a interventions to addrelated to the self in On 04/03/12, there mitten to right handremoving the wound the stage IV pressor hip. The physician's ordereviewed. Resider (milligram) 1 tablet Geodon 40 mgs da Ativan 1 mgs every On 07/17/12, Ativa changed to Ativan was discontinued. The nurse's notes dated 06/02/12 at Resident #68 was trying to remove the of blood was noted mitten was remove with warm water, of and posterior area attending physician Rocephin (an antib (intramuscular) time anesthetic) and to index finger with be daily until healed. That the dressing to intact and no drain	olar disorder requiring the use ropic medications. " The care measurable goal and dress the care and treatment	F	323	F 323 2. Systemic changes include re-edo of the nursing staff by the Director Nursing to assure devices/intervent prevent falls are maintained as indit the resident's plan of care. This edwill be incorporated into the facility education program at the time of his annually. A nurse will immediately the resident after a fall and implement corrective/preventive action. A porreview will be conducted by the Interdisciplinary Team the next but day to determine if the appropriate prevention strategies are in place.	of ions to cated in ication y re and y assess ent st fall	

STATEMENT (OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WIN	G			3/2012	
	COVIDER OR SUPPLIER			500	T ADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170	0000	372012	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	no evidence in the re pharmacological interest or tried to prevent the happening again other. Review of the psychoflow records for June no self injurious behavioral symptoms. Nurse #3 was intervied have been listed undenot. The notes dated 06/00 that Resident #68 was cratches to the neck 06/08/12 at 11 PM no inflicted scratches on administered as scheevidence in the reconstructions were imprevent the self injurichappening again other. On 06/04/12 at 2:28 indicated that the harthere was no doctor hand mitten, it was preadministration due to the nurse's notes daresident noted to have scratches to chest an observed scratching adisplayed signs and street was no evident.	ras administered. There was cords that non eventions were implemented a self injurious behavior from er than Ativan. Pactive medication monthly and July, 2012, there was evior listed under target at 25:05 PM, and Sewed. She stated it should be target behavior but it was everal at 10:00 AM revealed as in bed, she had several at the sewer and the sewe	F	323	I. Monitoring of performance conducted by the Acuity Interventich consists of the Administ of Nursing, 3 RN Supervisors, Coordinator, Dietary, Social W Coordinator and Therapy, on a will audit five medical records these residents to assure that appearant intervention, assess planning are in place. If the Administration Team decides that behavior issues require an outs referral will be made to the loc mental health service for an evadmissions will be reviewed w Acuity Intervention Team mee appropriate behavior interventiand care planning are in place what changes need to be made monitoring for Resident Behav shared with the Director of Nuweekly basis and with the Qua Assurance/Process Improveme monthly for a minimum of nin which time the frequency of m be determined. The Wound Cawill assess all bruises, skin teabites weekly and document sta Ulcer/Wound Identification an Report. The Acuity Interventimonitor the progress records we completeness and wound statu Results of this monitoring for Behavior and Wound Status w with the Director of Nursing of and with the Quality Assuranc Improvement Committee	rention Team, rator, Director MDS Tork, Admission weekly basis, and observe oppopriate ment and care suity a certain ide expert, a al county aluation. New eekly at the ting to assure ion, assessment or to determine. Results of this for will be raing on a lity int Committee ety days at onitoring will re Coordinator rs, wounds and tus on the d Progress on Team will reekly for s. Resident ill be shared in a weekly basis		
	displayed signs and s There was no eviden	symptoms of agitation.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345051	B. WNG_		08/	C 03/2012	
	OVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COL 500 MORVEN RD WADESBORO, NC 28170	DE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENT	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	happening again. On 07/10/12, there discontinue the tre discontinue the tre the area had heale Nurse #1 was inte was the treatment she looked at the healed so she discoming from left hon hand. Large an face and clothing, that the attending resident was sent 7:45 AM, Residen from the emergen PM, Nurse #2 was stated that she was She clarified that the hand and not the left was on bolus during her shift (1:1) went to the room to the right hand waremoved her hand agitated. After she that the bleeding was removed first and second ficoming up from the indicated that she	the self injurious behavior from atment to the right index finger, ad. On 08/01/12 at 3:10 PM, rviewed. She stated that she nurse on 07/10/12 and when right index finger, the area was continued the treatment. Idated 07/14/12 at 5:35 AM resident with profuse bleeding and related to resident chewing mount of blood in the mouth, The notes further indicated physician was notified and the to the emergency room. At the 48 was back to the facility by room. On 08/01/12 at 10:10 interviewed by phone. She is the night nurse on 07/14/12, the affected hand was the right reft. She revealed that Resident tube feeding every 2 hours 2 AM, 2 AM and 4 AM). She on give Resident #68 her 4:00. She found large amount of the mouth, face and clothing, in her mouth and when she is from her mouth and when she is from her mouth she became the cleaned the hand, she noticed was coming from her hand. The including the cuticle from the ingers and the fingernails were the base of the nail. She further had to remove a lot of skin bouth. She reported that prior to	F 32	Monitoring will continue ninety days at which time monitoring will be determ 2. The RN Supervisor wi basis monitor residents at plans to ensure that approdevices/interventions to place. Five residents will week by the Acuity Intervention of this monitoring with the Director of Nurs with the facility Quality / Improvement Committee ninety days at which time monitoring will be determined to the committee of the	the frequency of nined. If on an ongoing and review care oppriate or event falls are in the reviewed each wention Team. If will be shared ing weekly and Assurance/Process for a minimum of efrequency of	8/29/12	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	·		c	
		345051	B. WING		30	3/03/2012	
	OVIDER OR SUPPLIER OMMUNITY HOSPITAL S	NF	5	REET ADDRESS, CITY, STATE, ZIP CODE 00 MORVEN RD VADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	saw the resident was gave the bolus tube of the bolus tube of the chief complaint was patient found chewing. On physical examina to have deep abrasion. The clinical impression abrasions right hand notes further revealed hand due to patient of thumb. The wounds (normal saline) and trapplied, covered with dressing was applied due to bleeding. Residue to bleeding. Residue to the facility with hand wounds daily wointment (an antibiotial adhesive dressing an ace wrap over dressing antibiotic) 500 mgs 3. The nurse's notes darevealed that there wered blood on the end hand. When the old thumb, first and secon have multiple area of nurse for this date/timinterview.	ent this way the last time she around 2:00 AM when she eeding. records dated 07/14/12 notes revealed under the 'bleeding fingers right hand, g flesh from hand by staff." tion, the resident was noted ins on right hand fingers. In was self inflicted from patient biting. The dimultiple wounds on right hewing on first 2 fingers and were cleaned with NS iple antibiotic ointment was 4 x 4 and kling. Pressure to the base of the thumb ident #68 was transferred the orders to clean the right with Hibiclens, Neosporin ic), dress fingers with non dicover with bulky dressing, and Augmentin (an times a day for 10 days. ted 07/14/12 at 12:30 PM as a small amount of bright of the dressing to right dressing was removed, the and fingers were noted to skin missing. The assigned ne was not available for	F 323				
		dent's right hand dressing amount of bloody drainage,					

STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345051	B. WN			C 08/03/2012	
NAME OF PROVIDER OR SUPPLIER ANSON COMMUNITY HOSPITAL SN			500 M	ADDRESS, CITY, STATE, ZIP CODE SORVEN RD ESBORO, NC 28170		
PREFIX (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
indicated that the dress noted multiple areas of thumb, first and second hand. Moderate amour noted from the areas. It date/time was not avail. The nurse's notes date indicated that the index dressing was changed indicated that an order of untied mitten. Reside the weekend by chewing history of continually regastrostomy tube and of the ulcer/wound identificated were reviewed the notes indicated scalarinage, very irregulate index finger and thumb blood but did not remowere 75 % necrotic and covering or surface lay 07/20/12, the fingers stand 25% pink and dens scant bloody drainage, indicated that eschar protes revealed that the requested surgical con AM, Nurse #5 was intested as word 2012. She also indicated socks were tried for Refrom biting her fingers.	d. At 10:15 AM, the notes sing was changed and skin missing from the difingers and top of the not of bright red blood was The assigned nurse for this table for interview. d 07/16/12 at 10 AM of finger was red, the at 11:30 AM, the notes was written to clarify use dent has harmed self overing on hand. She had emoving fully inflated foley, dressing to wound. fication and progress on 07/16/12 (no time), and amount of bright bloody rly shaped wound over on Both were dark like old we with dressing. They d 25 % denuded (outer ter of skin is removed). On till had 75% necrotic tissue uded. No odor and with on 07/28/12, the notes exersisted. The 07/30/12 of doctor was in and soult. On 08/01/12 at 10:15 erviewed. She stated that and care nurse in June, ted that hand mitten and esident #68 to prevent her	F	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
11010101	OGMICOMON	IDENTIFICATION OF THE PROPERTY	A. BUIL	DING			
		345051	B. WING		<u>.</u>	08/	C 03/2012
	ROVIDER OR SUPPLIER	SNF		500 M	ADDRESS, CITY, STATE, ZIP CODE IORVEN RD ESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X6) COMPLETION DATE
F 323	mitten (untied) to right hand to prevent self injury, removal of dressing, foley catheter, and g-tube, remove every shift to provide care, monitor status.		F	323			
	indicated that the phy resident's increased a arm and biting at her 1 mg IM was received the records that non pinterventions were im	•					
	Resident #68 was se physician. New order index finger, culture a index finger wounds antibiotic) 100 mgs for The physician's programmer.	or 10 days were received. ress notes dated 07/24/12 dent had finger bites with	The second secon				
	index finger wound d	itivity report of the right ated 07/24/12 was " nosa, heavy growth."	:	·			
	revealed that the nur- #68's room to assess wound tissue was ye necrotic tissue mixtur noted imbedded in w was noted with blood foul odor. The physic	ted 07/28/12 at 12:45 PM se was called to Resident the right index finger. The llowish, red slough with re. Several maggots were ound tissue. The wound ty yellowish drainage with cian was notified with new ght index finger with soap					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	and the state of t		A. BUILDING			С
		345051	B. WING		08	3/03/2012
	OVIDER OR SUPPLIER	SNF	5	EET ADDRESS, CITY, STATE, ZIP CODE 00 MORVEN RD		
AII.0011 0			. V	VADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIEN	ITATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	ne 27	; F 323	! :		:
1 020	1	wash and xeroform dressing	. 020	•		i
	drily V roy of the ri	ight hand was also ordered.	ļ :	:		İ
	The notes further to	vealed that Nurse #3 was	3	•		i
		f Resident #68. Nurse #3 had		•		
		cts around the necrotic tissue.	;		•	
		that she had removed 4		1		i
		om the wound. She cleaned		:		
		ap and water and covered with	:			i
		08/01/12 at 5:05 PM, Nurse		T.		
		She stated that she was the				i i
		when she found maggots on				
		r wounds. She further stated	1	1		1
		d socks were tried to prevent	1			i
		ingers but they did not work,	i			
		able to remove them.				:
			i	i		İ
	The x-ray report of	the right hand dated 07/28/12				
	was soft tissue swe	lling and no fracture or	i i			1
	destruction of bone		į			1
			:			1
	The nurse's notes of	lated 07/29/12 at 10 AM	1	•		
	indicated that the d	ressing was changed to the				
		index finger. The color	I	:		;
	remained dull with	small section of necrotic				į
	tissue.					
			İ			
		dated 07/30/12 at 6:10 PM				; ;
		hysician came to see Resident	i i			!
		ipro (an antibiotic) 500 mgs				
		lays and surgical consult for				
		right index finger. On 08/01/12	Į į			!
		#4 was interviewed. She	1	:		i
	stated that she was	s with the physician when he	;			:
ı		on 07/30/12. She found the				
i	_	ated with slough tissue and	1			
l	with yellowish drair	nage.	4			
l		e and allowed the control of	•			;
	On 08/01/12 at 9:4	5 AM, Nurse # 5 was observed	I .			;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WIN			C 08/03/2012	
	ROVIDER OR SUPPLIER OMMUNITY HOSPITAL	SNF		500 N	ADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	during the dressing of Resident #68. The robserved to be necroomed to be necroomed to be necroomed to be necroomed to be necroomed to be necroomed to be necroomed to be necroomed to be necroomed to be necroomed to be necroomed to be necroomed to no no no no no no no no no no no no no	change to the right hand of tight index finger was offic, swollen and with odor. Wish wound bed. The thumb se #5 was observed to clean dine, xeroform was applied dressing. OAM, administrative staff #1 e stated that she was aware en Resident #68 had chewed cated that she had not tried e from a hand mitten to ng her fingers.	F	323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/13/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ANSON COMMUNITY HOSPITAL SNF (CA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 29 aside from the hand mitten. The nurses should be monitoring her self injurious behavior too and document it on the psychoactive medication monthly flow record every shift. On 08/02/12 at 1:30 PM, Nurse #3 indicated that Resident #68 was back and debridement was not performed. She further stated that the hospital staff stated that the surgeon had referred Resident #68 to an orthopedic doctor for amputation of the right index finger. The surgical consultation report dated 08/02/12 was reviewed. The report revealed examination of the right index finger. The debridement was unlikely to be of benefit considering extensive tissue loss. Recommend treatment by orthopedic, hand surgeon and wound care. On 08/02/12 at 2:20 PM, the hospital staff was interviewed. She stated that she was a surgical service supervisor who worked with the surgeon. She indicated that because of the extensive tissue loss, debridement was not of benefit so the	STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
ANSON COMMUNITY HOSPITAL SNF C44) ID SUMMARRY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) F 323 Continued From page 29 aside from the hand militen. The nurses should be monitoring her self injurious behavior too and document it on the psychoactive medication monthly flow record every shift. On 08/02/12 at 1:30 PM, Nurse #3 indicated that Resident #68 was back and debridement was not performed. She further stated that the hospital staff stated that the surgeon had referred Resident #68 to an orthopedic doctor for amputation of the right index finger. The surgical consultation report dated 08/02/12 was reviewed. The report revealed examination of the right index finger. The debridement was unlikely to be of benefit considering extensive tissue loss. Recommend treatment by orthopedic, hand surgeon and wound care. On 08/02/12 at 2:20 PM, the hospital staff was interviewed. She stated that she was a surgical service supervisor who worked with the surgeon. She indicated that because of the extensive tissue loss, debridement was not of benefit so the			345051	B. WNG		08.	/03/2012
PREFIX TAG			:NF	500 N	MORVEN RD		
aside from the hand mitten. The nurses should be monitoring her self injurious behavior too and document it on the psychoactive medication monthly flow record every shift. On 08/02/12 at 1:30 PM, Nurse #3 indicated that Resident #68 was back and debridement was not performed. She further stated that the hospital staff stated that the surgeon had referred Resident #68 to an orthopedic doctor for amputation of the right index finger. The surgical consultation report dated 08/02/12 was reviewed. The report revealed examination of the right index finger. The debridement was unlikely to be of benefit considering extensive tissue loss. Recommend treatment by orthopedic, hand surgeon and wound care. On 08/02/12 at 2:20 PM, the hospital staff was interviewed. She stated that she was a surgical service supervisor who worked with the surgeon. She indicated that because of the extensive tissue loss, debridement was not of benefit so the	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
surgeon had referred Resident #68 to the orthopedic doctor for amputation of the right index finger. On 08/03/12 at 1:58 PM, Nurse Aide #1 was interviewed. She stated that she had observed Resident #68 biting her fingers sometime in July prior to having her fingers injured. She added that she was wearing a hand mitten but she was able to remove it. She further stated that the nurses were aware of this behavior. The administrator was notified of the immediate jeopardy on 08/02/12 at 2:45 PM.	F 323	aside from the hand be monitoring her set document it on the promorthly flow record of the control of the contr	mitten. The nurses should if injurious behavior too and sychoactive medication every shift. PM, Nurse #3 indicated that ack and debridement was not her stated that the hospital burgeon had referred orthopedic doctor for hit index finger. ation report dated 08/02/12 report revealed examination yer. The debridement was effit considering extensive mend treatment by regeon and wound care. PM, the hospital staff was ated that she was a surgical tho worked with the surgeon. Recause of the extensive ment was not of benefit so the did Resident #68 to the ramputation of the right PM, Nurse Aide #1 was ated that she had observed ther fingers sometime in July ingers injured. She added g a hand mitten but she was the further stated that the of this behavior.	F 323			

Event ID: EPTT11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345051	B. WIN	3		08	C /03/2012
	OVIDER OR SUPPLIER	SNF	•	500 N	ADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	e 30	F	323			
	The facility provided compliance on 08/03	a credible allegation of 3/12 at 7:08 PM.					
	The allegation of cor	mpliance indicated:					1
	medical issues. Folk Resident #68 will be due to multiple medi medical situation wh Hemorrhage, severe seizure disorder, lon pain, agitation, & mu House was recomm doctor), Chief Medic hospice care networ management to con • A: Resident Behave with behaviors have by the cited deficien total) and care plans documented behavior Administrator, Direc Supervisors, on Augappropriate behavior No additional reside behaviors were iden additional resident w (Resident #51) was	of the hospital) for unrelated owing hospitalization, transferred to hospice house cations, and very complex ich includes Intracranial Altered Mental Status, & g history of rash, itching, altiple infections. Hospice ended by (name of the al Officer for (name of the al Officer for (name of the k) for medication trol seizures & behaviors. Aviors: Because all residents the potential to be affected cy, all medical records (52 for residents with ors were re-evaluated by tor of Nursing, and (3) RN just 2, 2012 to assure in interventions were in place. Into with self-injurious behaviors evaluated by the primary care 13, 2012 and no interventions					
	with wounds have th	on: Because all residents ne potential to be affected by all residents currently					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		08	C /03/2012
	OVIDER OR SUPPLIER	SNF	500 1	TADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	the Wound Care Co and July 31, 2012. clean with no signs maggot infestation. - A. Resident Beha started on August 3 Educational Sheet, for staff to report be Charge Nurse who as indicated. If resid immediate serious placed on 1:1 moni family/RP will be no transferred to the eneeded. The Charge 24-Hour report and Acuity Intervention Administrator, Direct Supervisors, Dietar Coordinator, & The interventions could appropriate. This Eneroyided to 293 em staff and ancillary staff and ancillary staff and ancillary staff on how to han behavior and behave August 3, 2012 and 2012. The inservice Director of Nursing Supervisor. In add behavior and intervall staff by (name of 6, 2012 and Augus be video taped for	ge 31 catments were evaluated by pordinator on July 30, 2012 All wounds were found to be or symptoms of infection or aviors: Initial staff education of 2012, via Behavior which emphasized the need enaviors immediately to the will implement interventions dent behaviors pose an threat, the resident will be toring, the physician and offied, and the resident is mergency department if ge Nurse will document on the will be reviewed daily by the Team, which consist of the ctor of Nursing, 3 RN by, Social Worker, Admissions rapy, so appropriate be reviewed and revised as sehavior Education Sheet was apployees, which includes all staff that provide services to nal mandatory inservices for all dle residents with self injurious vior monitoring began on divill conclude on August 10, ses will be conducted by the Administrator and RN ition, education on resident ventions will be conducted for if the psychologist) on August 17, 2012. This inservice will additional staff education able to attend the inservices	F 323			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WIN	G		C 08/03/2012	
	ROVIDER OR SUPPLIER OMMUNITY HOSPITAL	SNF		500 1	I ADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 4	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	return to work. This into the facility orient & annually. B. Wound Evaluation all nursing staff begat conclude on August include identification signs and symptoms maggot infestation. conducted by the Diale Administrator and R wound is identified, generated and immerimplemented. The indocumented on the Charge Nurse and Intervention Team. will evaluate all wou assure appropriate to place. Staff unable to required to receive the work. This education facility orientation programmally. A. Resident Behavior Team, which consists of Nursing, 3 RN Suresidents.	ceive education prior to education will be incorporated tation program for new hires an: Mandatory inservices for an on August 3, 2012 and will 10, 2012. Education will and reporting of wounds, so of infection, and fly and/or. The inservices will be rector of Nursing, N Supervisor. At the time a can incident report will be ediate interventions intervention will be 24 hour reported by the exported through the Acuity. The Wound Care Coordinator ands on a weekly basis to reatment/interventions are in the attend the inservices will be education prior to return to a will be incorporated into the orgam for new hires &	F	323			
	a weekly basis, will a observe these reside appropriate behavio & care planning are Team identifies that outside expert, a ref	Coordinator, & Therapy, on audit five medical records & ents to ensure that ral intervention, assessment, in place. If Acuity Intervention behavior issues need an erral will be made to (name of ntal health service) for an					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345051	B. WIN	G		08/	03/2012
	OVIDER OR SUPPLIER	NF	1	500	ET ADDRESS, CITY, STATE, ZIP CODE MORVEN RD ADESBORO, NC 28170		
			1	1		AN .	: «
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E 000			!	000]
F 323	, , ,		F	323			!
		issions will be reviewed	:				İ
		ntervention Team meeting to	į				
	ensure appropriate b	ehavioral intervention,					
		planning are in place or if		į			i
	changes need to be	made. Family and staff					
	involved in resident of		i	!			
	opportunity to provide	e input into the care plan					1
	process to assure re-	sident centered care.	i	į			·
	Wound Evaluation:	The wound care nurse will	ļ	1			!
	,	kin tears, wounds and bites	İ	;			
	weekly and documer			1			
		gress report. The Acuity		i			:
		Il monitor the progress report	*				i
	weekly for completer		1	:			:
	weekly for completer	less and progress.		Í			1
	Doguita of the mon	toring will be shared with the		i			
		reekly and with the facility		1			
		nd Assessment Committee					•
		will continue a minimum of		1			:
		time the Quality Assurance					·
	•	mmittee will determine if the					
		resolved. If it has been	:				
		deficiency has been resolved,		1			}
	monitoring will be co	nducted on a quarterly basis.					; :
	Corrective Action Da	ite: August 3, 2012		 			,
	771 12 11 11 11						1
		on was verified on 8/03/12 at					
		ed by staff interviews and					ŧ .
		ice signed in sheets on	!				•
		what type of behavior to	4				1
		you going to report, what					
	would you fill out if b	ehaviors noted and reported	•	1			1
		interventions would you do					4
		njury. Interview also with the		:			•
		evealed that the charts of		i			i
	residents with behav	vioral issues were reviewed		1			1
{				i			<u> </u>

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU A. BUILE	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345051	B. WING	· · · · · · · · · · · · · · · · · · ·	08	C /03/2012	
	OVIDER OR SUPPLIER DMMUNITY HOSPITAL S	NF	•	STREET ADDRESS, CITY, STATE, ZIP 500 MORVEN RD WADESBORO, NC 28170	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE / CROSS-REFERENCED) DEFICE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	and wounds were assinfection/infestation. 2. Resident # 11 was facility 11/21/08. Cur Seizure disorder, Dei Joint Disease. An Annual Minimum dated 11/10/11 indicaterm and long term moderately impaired required extensive as transfers and toilet us during the assessme impaired in that she whuman assistance fo standing position, mosurface to surface trafunctional ROM was lower extremity. A Care Area Assessment assessment occurred (no injury with falls). risk for falls based or cognition causing a pneeds (dementia), impsychotrophic medic of the assessment, sfall mat and a non-slift seizure disorder.	entions and care planning sessed for possible soriginally admitted to the mulative diagnoses included mentia and Degenerative Data Set (MDS) assessment atted Resident #11 had short nemory impairment and was in decision-making. She esistance with bed mobility, se. Ambulation did not occur not period. Balance was was only able to stabilize with a moving from a seated to oving on and off the toilet and ansfers. Impairment in noted on one side for the ment (CAA) summary for falls atted falls since prior d on 10/23/11 and 10/24/11 Resident #11 was at high an her history of falls, impaired over awareness of safety apaired balance and use of attons (Haldol). At the time he was on a low bed with a ip pad had been applied to	F3		ENGY)		
		p prevent further falls. She rm to alert staff when she unassisted.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		'	LTIPLE CONSTRUCTION	(X3) DATE : COMPL		
/ = *** ***		345051	A. BUILE B. WING		- 08	C 3/03/2012
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 500 MORVEN RD WADESBORO, NC 28170	1	
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F 323	Resident # 11 was for side. A cut on her left physician and family was sent to the eme. A Confidential Occur 6:45 AM. revealed For Iying on her left to the left eyebrow was tatus before fall: no rails, call bell access confused. A Post Fall Review for Resident #11 was ly fall. The fall mat way was in the low position.	M., nursing notes revealed bund on the floor lying on left if eyebrow was noted. Her were notified. Resident #11 regency room for treatment. Trence Report dated 6/2/12 at tesident #11 was found on the iside with a noted laceration with a small amount of blood. The prestraints in place, no side	F3			
	#11 was moderately Resident #11 had of fall with injury (exce assessment done of On 7/15/12 at 6:55 Resident #11 was fall	7/13/12 indicated Resident rimpaired in cognition. ne fall without injury and one pt major injury) since the last n 4/19/12. PM, nursing notes revealed bund sitting up on floor beside injury was noted and no				
	at 6:55 PM. indicated the floor in a seated	urrence Report dated 7/15/12 ed Resident #11 was found on I position. No injury was re the fall was not completed.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SU COMPLE	
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F 323	assistive devices at timat on the floor. The A Care plan reviewed problem of potential fimpaired mobility, his psychotropic medical problems. The goal on injury as a result of next review. Approach low bed with fall mat injury from falls from wheelchair for safety, wheelchair " An observation on 8// Resident #11 lying in was not a fall mat on the floor she expected that all in place which includition. On 8/2/12 at 9:49 All observed sitting in a 1/2 the wheelchair did in the wh	eport dated 7/15/12 revealed the time of the fall included care plan was updated. If on 7/18/12 included a for falls secondary to tory of falls, use of tions and mood and behavior lead Resident #11 will have of a fall at any time over the ches included: "Provide a to help reduce the risk of the bed. Antitippers to the Anon-slip pad to to Anon-slip pad to the floor beside the bed. In, Nurse #1 went to and noted that there was not beside the bed. She stated interventions for falls to be dea fall mat to be on the the was antitippers. There in the wheelchair with a cloth	F	323	DEFICIENCY		
	assistant had placed wheelchair and she s	, Nurse #1 stated the nursing Resident #11 in the wrong should have been in the intitippers. During the					 - - -

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					<u> </u>
STATEMENT C	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MI A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	Continued From page	ne 37	! - - -	323			
1 020	interview, she instru	octed nursing staff to take to her room and put her in the		i !			
	stated Resident #11 the wheelchair in the resident in the room the red non-slip pac other wheelchair be During the interview	n, nursing assistant (NA) # 2 did not have her name on e room. She said the other indicated the wheelchair with did was hers so she knew the elonged to Resident #11. N, NA # 2 further stated the fall floor when she went in the NM.		: :			
F 334	stated she expected interventions for fall included the fall man wheelchair and the 483.25(n) INFLUEN	PM., Administrative staff #2 d nursing staff to use all of the ls for Resident #11 which at, antitippers on the non-slip pad. NZA AND PNEUMOCOCCAL	F	334	F 334		
SS=B	The facility must de that ensure that — (i) Before offering the each resident, or the representative receipments and potential memorization; (ii) Each resident is immunization Octon annually, unless the contraindicated or immunized during (iii) The resident or representative has immunization; and	sives education regarding the tial side effects of the soffered an influenza ber 1 through March 31 e immunization is medically the resident has already been this time period; the resident's legal the opportunity to refuse			Resident#1, 5, 11, 19 were pronecessary education and documplaced in the medical record. All residents and/or their responser provided with the current 2012) Centers for Disease Confidency and pneumococcal veducation. This has been document resident's medical record indicating that this information provided has been completed. Worker.	onsible party t (2011 - ntrol (CDC) vaccination mented in I. A log n was	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPLE	TED
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F 334	following: (A) That the resider representative was p the benefits and pote immunization; and (B) That the resider influenza immunization influenza immunization contraindications or a second that ensure that — (i) Before offering the immunization, each a legal representative the benefits and pote immunization; (ii) Each resident is a second immunization, unless medically contraindical already been immunization; and (iv) The resident or the representative has the immunization; and (iv) The resident or the representative was proposed to the benefits and pote pneumococcal immunication; and the benefits and pote pneumococcal immunication; and the benefits and pote pneumococcal immunication or reconstraindication or reconstra	tor resident's legal rovided education regarding intial side effects of influenza at either received the control of the contro	F	334	On admission and annually, the a education will be provided to all and/or their responsible party by Worker who will also document of this information in the residen record. If the CDC immunization is updated, all current residents a responsible party will receive a cassure changes are communicate. The Administrator or the Directo Nursing will review the immunizeducation portion of the New Ad Log weekly to assure that all new admissions as well as existing rehave been provided the current C influenza and pneumococcal vaceducation. Results of the monito be shared during the monthly Qu Assurance and Process Improver Committee for a minimum of nir which time frequency of monitor determined.	residents the Social provision t's medical education ad/or opy to d. r of ation mission f sidents DC cine ring will ality ment ety days at	8/29/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	S FOR MEDICARE & OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE (CONSTRUCTION	(X3) DATE S	
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	OVIDER OR SUPPLIER	SNF		500 N	r address, city, state, zip code Morven RD DESBORO, NC 28170		
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F 334	years following the fill immunization, unless	nization may be given after 5 rst pneumococcal a medically contraindicated or sident's legal representative	F	334			
	by: Based on record rev facility failed to provi benefits and potentia immunization before	T is not met as evidenced view and staff interview, the de education regarding the al side effects of the influenza offering the immunization to #11, #69) of 5 sampled ngs include:	: :				
	Vaccination (date of The policy read in painfluenza immunizate each resident or the representative educand potential side et assess each resider contraindications. It resident's medical reminimum: that the resident in the resident is the resident in the	ation regarding the benefits fects of the immunization and ht for possible medical Documentation in the ecord will include at a esident or legal representative tion regarding the benefits					
T TO SAME THE THE TO SAME THE TO SAME THE TO SAME THE TO SAME THE	07/2/1997 with mult Dementia. The qua	admitted to the facility on iple diagnoses including arterly (MDS) Minimum Data ed 07/05/12 indicated gnitively intact.					

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: A. BUILDING			E CONSTRUCTION	(X3) DATE SUF COMPLET	
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F 334	Continued From pag	e 40	F	334			
	Resident #1 had recon 09/26/11. There that education regard side effects of influent provided to the residence on 09/26/12 at 3:05 PM pneumonia vaccine every year. She revidend stated she could in the chart that the interesidents/ family On 8/2/12 at 4:30 PM the Admissions Coordinate and the information to the putting any information that the information of the informati	I., Nurse #2 stated she was redinator during the influenza of remembered sending out the families. She did not recall on in the residents' records and been sent. M., Administrative staff #1 do sent out the educational of pneumonia vaccine to the fast year and had spoken to the influenza vaccine during fineeting but they had not fineal record that the education resided in the facility since fagnoses including cident (CVA) and Multi-infarct terly MDS assessment dated sident #1 was severely					

STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345051	B. WING		08	3/03/2012
	OVIDER OR SUPPLIER	SNF	6	EET ADDRESS, CITY, STATE, ZIP COD 30 MORVEN RD JADESBORO, NC 28170	E	
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F 334	Resident # 5 had recon 10/8/11. There we ducation regarding effects of influenza is the resident's family On 8/2/12 at 3:05 Pl pneumonia vaccine every year. She reviand stated she could in the chart that the the residents/ family On 8/2/12 at 4:30Ph the Admissions Cooseason last year and the information to the putting any information on 8/2/12 at 6:00 P stated the facility has material about the firesidents' families I the residents' families I the residents' about a Resident Council recorded in the mediad been provided. 3. Resident #11 was facility on 11/21/08 including Dementia	nization Record revealed that believed the Influenza Vaccine was no evidence that benefits and potential side mmunization was provided to prior to the immunization. M., Nurse #1 stated the flu/ information was sent out ewed the medical records do not find any documentation information was sent out to members. M., Nurse #2 stated she was redinator during the influenza documentation of the families. She did not recall it ion in the residents' records had been sent. M., Administrative staff #1 and sent out the educational out/ pneumonia vaccine to the ast year and had spoken to the influenza vaccine during meeting but they had not dical record that the education as originally admitted to the with multiple diagnoses and Atypical Psychosis. The	F 334			
	indicated that Resid	essment dated 7/13/12 dent #11 had memory s moderately impaired in ills.		:		
			1			i

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		08	C /03/2012
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F 334	Resident #11 had on 9/26/11. There education regardir effects of influenzathe resident 's fan On 8/2/12 at 3:05 pneumonia vaccin every year. She reand stated she coin the chart that the residents/ fam On 8/2/12 at 4:306 the Admissions Coseason last year at the information to putting any inform that the information On 8/2/12 at 6:00 stated the facility I material about the residents' families the residents' families the resident Councrecorded in the methad been provided 4. Resident #69 1/4/11 with multipl and Depression, assessment dated Resident #69 had	nunization Record revealed that received the Influenza Vaccine was no evidence that in benefits and potential side a immunization was provided to nily prior to the immunization. PM., Nurse #1 stated the flu/ e information was sent out eviewed the medical records and not find any documentation in information was sent out to fly members. PM., Nurse #2 stated she was condinator during the influenza and remembered sending out the families. She did not recall ation in the residents' records in had been sent. PM., Administrative staff #1 had sent out the educational flu/ pneumonia vaccine to the staty year and had spoken to but the influenza vaccine during fill meeting but they had not redical record that the education decical record that the education decical record that the education decical record that the education decical record that the facility rediagnoses including Dementia The Significant change MDS is 5/10/12 indicated that it short term/ long term memory as severely impaired in	F 334			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 334	Review of the Immur	nization Record revealed that	F:	334			
	on 10/8/11. There w education regarding	benefits and potential side					
	the resident's family	nmunization was provided to prior to the immunization.					
	pneumonia vaccine i every year. She revie	M., Nurse #1 stated the flu/ information was sent out sewed the medical records I not find any documentation	!				
	\$	nformation was sent out to	i				<u> </u>
	the Admissions Cool	I., Nurse #2 stated she was dinator during the influenza I remembered sending out	1				:
	the information to the	e families. She did not recall on in the residents' records	i	i			
	stated the facility ha	M., Administrative staff #1 d sent out the educational u/ pneumonia vaccine to the					
	residents' families la the residents' about	ast year and had spoken to the influenza vaccine during neeting but they had not		:			
F 356	recorded in the med had been provided. 483.30(e) POSTED	ical record that the education	F	356	F 356		i
SS=C	1	et the following information on			The nursing staffing posted at the the survey was modified to reflect appropriate levels.		
		and the actual hours worked		:	Correct nursing staffing will be p daily basis.	osted on a	; ; [
	by the following cate	egories of licensed and					

	ROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345051	B. WIN			C 08/03/2012	
NAME OF PROVIDER OR SUPPLIER ANSON COMMUNITY HOSPITAL SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 500 MORVEN RD WADESBORO, NC 28170		0 MORVEN RD		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 356 Continued From page 44 unlicensed nursing staff dire resident care per shift: - Registered nurses Licensed practical nur vocational nurses (as defined nurse aides.) - Certified nurse aides Certified nurse aides Resident census. The facility must post the mespecified above on a daily be of each shift. Data must be of Clear and readable formation of a prominent place readeresidents and visitors. The facility must, upon oral make nurse staffing data are for review at a cost not to estandard. The facility must maintain the staffing data for a minimum required by State law, whice This REQUIREMENT is not by: Based on observation and facility failed to post accurate staff posting by including sustaff. The findings included During the initial tour of the 11:30 AM, the staff posting include 2 RNs (registered medical nurses) shift. The facility was obserunits. Interviews conducted	urse staffing data basis at the beginning posted as follows: at. dily accessible to for written request, vailable to the public exceed the community the posted daily nurse of 18 months, or as shever is greater. of met as evidenced staff interview, the ste data on the daily upervisory nursing d: facility on 7/30/12 at was observed to nurses) and 4 LPNs for the 7/30/12 7-3 rved to have 4 nursing	F	356	F 356 A review of current administrative responsibilities was conducted and that are "directly responsible for recare" are well defined. The RN Supervisor will on a daily monitor the nursing staffing posting assure accuracy and completeness. of this monitoring will be shared w facility Quality Assurance/Process Improvement Committee monthly minimum of ninety days at which the frequency of monitoring will be determined.	those sident basis g to Results ith the for a time	8/29/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ļ	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 371 SS=D	nursing unit. On 8/2/12 at 12 PM, observed to include shift. During an interview Administrative Staff the posting were sure on the staff posting their time helping wire assessments and distroughout the day. acknowledged that the have direct resident 483.35(i) FOOD PR STORE/PREPARE/ The facility must - (1) Procure food from considered satisfact authorities; and (2) Store, prepare, conder sanitary condered.	the staff posting was 3 RNs and 5 LPNs for the 7-3 on 8/2/12 at 12:15 PM, #1 indicated that the RNs on pervisors but were included because they spent some of th intravenous lines, ressings as needed Administrative Staff #1 the RN supervisors did not care assignments. OCURE, SERVE - SANITARY om sources approved or tory by Federal, State or local distribute and serve food litions	F3	All containers of exp were removed from discarded. The Certified Dietar the nourishment ref items were within ex Staff will check all refrigerators twice w occasion assure that	y Manager inspected rigerators to assure all expiration dates. nourishment weekly and will on each items in the as items being delivered		
	by: Based on observat policy review, the fa milk and juice in 2 o	NT is not met as evidenced ion, staff interview and facility acility failed to discard outdated of 4 nourishment refrigerators fall and Unit 4 -Rose Hall).					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345051	A. BUIL B. WIN			00/	C 03/2012
	(EACH DEFICIENC	ENF TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	500 WA	T ADDRESS, CITY, STATE, ZIP CODE MORVEN RD DESBORO, NC 28170 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	CORRECTION (X5) HON SHOULD BE COMPLETIC HE APPROPRIATE DATE	
F 371	part, "Discard items a >4 days or the manu passed (whichever c Observation of the U on 8/2/12 at 4:46 PM revealed 1 unopened juice with an expiration unopened single sen an expiration date of Observation of the U nourishment refrigerarevealed 4 unopened and 1 unopened single all with expiration date During an interview of Dietary Manager indiresponsibility of the couldated items from and the expired milks been discarded. 483.60(c) DRUG RE IRREGULAR, ACT of The drug regimen of reviewed at least one pharmacist.	ed "Resident Food Stock" revised10/09 read in as follows:" "Milk: if opened facturer expiration date has omes first)." Init 1 nourishment refrigerator and on 8/3/12 at 9:53 AM is single serve cup of prune on date of 7/12/12 and 1 we cup of orange juice with 7/31/12. Init 4 (Rose Lane) at on 8/3/12 at 10:02 AM is single serve milk cartons also serve cup of orange juice, tes of 7/31/12. Init 4 (Rose Lane) at on 8/3/12 at 10:02 AM is single serve milk cartons also serve cup of orange juice, tes of 7/31/12. Init 4 (Rose Lane) at on 8/3/12 at 10:02 AM is single serve cup of orange juice, tes of 7/31/12. Init 4 (Rose Lane) at on 8/3/12 at 10:02 AM is single serve cup of orange juice, tes of 7/31/12. Init 4 (Rose Lane) at one single serve cup of orange juice, tes of 7/31/12. Init 4 (Rose Lane) at one single serve cup of orange juice, tes of 7/31/12. Init 4 (Rose Lane) at one single serve cup of orange juice, tes of 7/31/12. Init 4 (Rose Lane) at one single serve cup of orange juice, tes of 7/31/12. Init 4 (Rose Lane) at one single serve cup of orange juice, tes of 7/31/12. Init 4 (Rose Lane) at one single serve cup of orange juice, tes of 7/31/12. Init 4 (Rose Lane) at one single serve cup of orange juice, tes of 7/31/12. Init 4 (Rose Lane) at one single serve cup of orange juice, tes of 7/31/12.		428	F 371 The dietary supervisor will aud refrigerators after each is stock all items are within dates. Resumonitoring will be shared with Administrator and shared with Assurance and Process Improve Committee on a monthly basis at which time frequency of commonitoring will be determined. F 428 The pharmacy recommendation Resident #14 were reviewed an was provided by the attending particular affected by this deficient practipharmacy recommendations for and August 2012 have been reveasure that all recommendation	ed to assure Its of the the the Quality ement for 90 days tinued a for d a response ohysician. to be ce. The June, July iewed to	8/29/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
I.D. LINTOI	John Common		A. BUII	.DING			С	
		345051	B. WIN	G		08/0	3/2012	
	ROVIDER OR SUPPLIER	SNF		500	ET ADDRESS, CITY, STATE, ZIP CODE MORVEN RD ADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 428	Continued From pag	e 47	F	428	F 428		: ! !	
	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow up on the consultant pharmacist's recommendation for the physician for 1 of 10 residents (Resident #14). The findings included: Resident #14 was admitted to the facility on 3/4/11. Diagnoses included old cerebrovascular accident, severe dementia, cachexia, anemia and vitamin D deficiency. Resident #14's physician orders included calcitriol (a drug used for management of hypocalcemia) 0.5 mcg (microgram) daily with a start date of				The pharmacy, at the time the recommendations are completed, copy to the physician's office as w provide copies to the Director of Y and the RN supervisor to assure fowith in a month. The RN Supervisor will on a daily monitor compliance to assure that response is timely. Dependent on of the recommendation, the superfollow-up with the physician as approximately.	vell as Vursing bllow-up basis physician the extent	8/29/12	
	dated 6/21/12 included decrease the calcitric hypercalcemia. Record review reveato the consultant phase A drug regimen revione of the hospital page.	macist drug regimen review ded a recommendation to iol to 0.25 mcg daily to avoid aled no documented response armacist's recommendation. ew dated 7/17/12, written by charmacists, included						
	#4 indicated that the either faxed the phy recommendations o to the hospital phane	on 8/1/12 at 3:10 PM, Nurse Consultant Pharmacist		1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345051	B. WNG		C 08/03/2012	
NAME OF PROVIDER OR SUPPLIER ANSON COMMUNITY HOSPITAL SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 500 MORVEN RD WADESBORO, NC 28170			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 428	recommendations we until the physician fax response. During an interview of hospital pharmacist windicated that the Correcommendations in a facility for the hospital fax to the physician. Nensure the physician recommendation. The the physician did not	re made to the physician red the facility with a m 8/3/12 at 12:10 PM, the who wrote the 7/17/12 review insultant Pharmacist put a manilla envelope at the pharmacist to pick up and to tracking was done to responded to the a pharmacist stated that if respond to a couple of months a second	F 428			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345051		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
				B. WING		08/30/2012		
NAME OF PROVIDER OR SUPPLIER ANSON COMMUNITY HOSPITAL SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 500 MORVEN RD WADESBORO, NC 28170					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMPLÉTION		
K 000	conducted as per T at 42 CFR 483.70(a Health Care section publications. This fa buildings, the older with building one Ty	de (LSC) survey was he Code of Federal Register (a); using the 2000 Existing of the LSC and its referenced acility is considered two portion and a newer addition upe V protected construction.	K (000				
K 029 SS=E	One hour fire rated fire-rated doors) or extinguishing syster and/or 19.3.5.4 prot the approved automoption is used, the aother spaces by sm doors. Doors are se field-applied protect	construction (with ¾ hour an approved automatic fire in accordance with 8.4.1 ects hazardous areas. When latic fire extinguishing system areas are separated from oke resisting partitions and alf-closing and non-rated or live plates that do not exceed bottom of the door are	КС		Pipe support attached aborated ceiling assembly homoved, causing damage to ceiling. Pipe support was re-attached to structure adjusted to carry weight pipe. Ceiling was repaired to restore rating. 8/31/2 Building was surveyed to identify other damage frowhat is suspected to be not minor earthquake tremo 8/31/2012	ad rated s and of ed 2012		
	Based on the obser during the tour on 8,6 was observed as no include: The boiler first floor has an uns ceiling at a pipe sup support above the ra	not met as evidenced by: rvations and staff interview (30/2012 the following item ncompliant, specific findings room in building one on the sealed penetration in the rated port attached to the steel ated ceiling. This support has			Monthly facility safety inspection rounds have be modified to include inspect of supports extending the rated ceilings and semi-asafety survelliance round will include inspecting e of structure for foundatidamage. 9/12/2012	ection rough innual is exterior	(X6) DATE	

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 A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		345051	345051 B. WING		08/30/2012		
NAME OF PROVIDER OR SUPPLIER ANSON COMMUNITY HOSPITAL SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 500 MORVEN RD WADESBORO, NC 28170				
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 029	•	ed the rated ceiling in that	K 029				

