IMENT OF HEALTH	AND HUMAN SERVICES			ORM APPROVED
RS FOR MEDICARE	& MEDICAID SERVICES			NO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	· ·	3) DATE SURVEY COMPLETED
345051		B. WING _		C 12/17/2014
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			405 SOUTH GREENE STREET	
NEALIN AND RENAD	IEITATION		WADESBORO, NC 28170	
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
INITIAL COMMENT	S	F 00	0	
		F 30	9	1/5/15
provide the necess or maintain the high mental, and psycho	ary care and services to attain nest practicable physical, social well-being, in			
by: Based on record refacility failed to obta laboratory results a 1 of 5 (resident #49 unnecessary medic lidoderm patch as c of 5 (resident #84) unnecessary medic 1. Resident #49 wa 11/18/10 with multip III Renal Disease, D Dementia, Hyperter Pulmonary Disease Cardiomyopathy, an Disorder. A review of the Min revealed the reside of a diuretic medica	eviews and staff interviews, the ain stat (immediately) s ordered by the physician for ) residents reviewed for ations and failed to administer ordered by the physician for 1 residents reviewed for ations. s admitted to the facility on ole diagnoses including Stage Diabetes Mellitus II, Ascities, nsion, Chronic Obstructive e, Congestive Heart Failure, nd Behavior Depressive	JATI IDE	Preparation and /or execution of this of Correction does not constitute admission or agreement by the provid the truth of the facts alleged or conclusions set forth in this statement deficiencies. The Plan of Correction is prepared and/or executed solely beca it is required by the provisions of Fede and State law. F309 Each resident must receive and facility must provide the necessary ca and services to attain or maintain the highest practicable physical, mental, a psychosocial well-being , in accordant with the comprehensive assessment of care. Corrective Action	ler of t of suse eral d the re and ce
	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER HEALTH AND REHAB SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS INITIAL COMMENT No deficiencies we complaint investiga ID # 083911. 483.25 PROVIDE O HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho accordance with the and plan of care. This REQUIREMEN by: Based on record re facility failed to obta laboratory results a: 1 of 5 (resident #49 unnecessary medic lidoderm patch as of of 5 (resident #84) fu unnecessary medic lidoderm patch as of of 5 (resident #49 wa 11/18/10 with multip III Renal Disease, D Dementia, Hyperter Pulmonary Disease Cardiomyopathy, ar Disorder. A review of the Mini revealed the reside of a diuretic medica	DEF CORRECTION       IDENTIFICATION NUMBER: <b>345051</b> PROVIDER OR SUPPLIER <b>HEALTH AND REHABILITATION</b> SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         INITIAL COMMENTS         No deficiencies were cited as a result of the complaint investigation survey of 12/17/14. Event ID # 083911.         483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING         Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.         This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to obtain stat (immediately) laboratory results as ordered by the physician for 1 of 5 (resident #49) residents reviewed for unnecessary medications and failed to administer lidoderm patch as ordered by the physician for 1 of 5 (resident #49) residents reviewed for unnecessary medications.         1. Resident #49 was admitted to the facility on 11/18/10 with multiple diagnoses including Stage III Renal Disease, Diabetes Mellitus II, Ascities, Dementia, Hypertension, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Cardiomyopathy, and Behavior Depressive Disorder.         A review of the Minimum Data Set dated 11/20/14 revealed the resident was assessed with the use of a diuretic medication.	RS FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES         OF DEFICIENCIES         PROVIDER OR SUPPLIER         LIDENTIFICATION NUMBER:         345051         B. WING         PROVIDER OR SUPPLIER         HEALTH AND REHABILITATION         SUMMARY STATEMENT OF DEFICIENCIES         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         INITIAL COMMENTS         F 00         No deficiencies were cited as a result of the complaint investigation survey of 12/17/14. Event ID # 083911.         483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING         Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.         This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to obtain stat (immediately) laboratory results as ordered by the physician for 1 of 5 (resident #49) residents reviewed for unnecessary medications and failed to administer lidoderm patch as ordered by the physician for 1 of 5 (resident #44) residents reviewed for unnecessary medications.         1. Resident #49 was admitted to the facility on 11/18/10 with multiple diagnoses including Stage III Renal Disease, Diabetes Melitus II, Ascities, Dementia, Hypertension, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Cardiomyopathy, and Behavior Depressive Disorder.	IMENT OF HEALTH AND HUMAN SERVICES       F         S3 FOR MEDICARE & MEDICAID SERVICES       OWE         or DEFICIENCIES       (X1) PROVIDERSUPPUENCLAN       (X2) MULTIPLE CONSTRUCTION         ABS FOR MEDICARE SA REDUCIDAD SERVICES       OWE         PROVIDER OR SUPPLIER       BUILDING       (X2) MULTIPLE CONSTRUCTION         HEALTH AND REHABILITATION       STREET ADDRESS. CITY, STATE, ZIP CODE       405 SOUTH GREENE STREET         WADESBORO, NC 28170       SUMMARY STATEMENT OF DEFICIENCIES       IN         REGULATORY OR USC DENTIFYING INFORMATION)       IN       PROVIDER STAN OF CORRECTIVE ACTION ANULD BE         REGULATORY OR USC DENTIFYING INFORMATION)       IN       PROVIDE CARE/SERVICES FOR       F 000         INITIAL COMMENTS       F 000       F 309       F 309         INITIAL COMMENTS       F 309       F 309         No deficiencies were cited as a result of the complaint investigation survey of 12/17/14. Event ID & 063911.       F 309         AB3.25 PROVIDE CARE/SERVICES FOR       F 309       F 309         HIGHEST WELL BEING       Each resident must receive and failed to administer ideotemp and a sordered by the physicial for 1 of 5 (resident #49) residents reviewed for unnecessary medications and failed to administer lidotemp atch as offield to administer relidotemp atch as offield to administer failure, Cardiomyopathy, and Behavior Depressive Disorder.       F309 Each resident must receive and failed to the faci

Electronically Signed

(X6) DATE 01/01/2015

PRINTED: 01/21/2015

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.

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI	E CONSTRUCTION		0938-039
	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:					· · /	PLETED
						С	
		345051	B. WING			12/*	17/2014
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ANSON HEALTH AND REHABILITATION			4	05 SOUTH GREENE STREET			
ANSON	NEALIN AND RENAD	SIEITATION		V	VADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 309	Continued From pa	age 1	F 3	09			
		-			Resident #49 had another CBC an	d BMP	
	The Plan of Care d	ated 11/26/14 indicated the			drawn on 12/18/2014 with results r		
		otential for dehydration			to the Physician.		
		f diuretic medication. The			Resident #84Ks Lidocaine patch w	/as	
		led to monitor labs as ordered,			discontinued on 12/18/2014 per		
		at indicated dehydration and to of any abnormal lab values.			PhysicianKs order.		
		or any abnorman ab values.			Corrective Action for those with the	2	
	A review of the Phy	vsician ' s Orders revealed an			potential to be effected		
		14 which stated " Complete					
		prehensive Metabolic Panel			An audit was done at the time of si		
		1C (Glycated Hemoglobin)			by the Director of Nurses (DON) a		
	Stat. "				her nurse managers of all charts lo		
	A novieur of lob and				for any potential missing labs. No		
		ory results collected 11/27/14 ved and reviewed by the facility			resident was found to be affected to	by this	
		onducted. The review revealed			alleged deficient practice. Also at the time of survey an audit	of all	
		ium level equal to 5.9			MARs was completed by the DON		
		(mmol/L) with a normal range			her nurse mangers for transcription		
		L to 5.1 mmol/L. The review			errors. No other resident was found		
		noglobin count equal to 8.7			affected by the alleged deficient pr	actice.	
		(g/dl) with a normal range					
		o 15.0 g/dl. The review also			Systemic Changes		
	a normal range equ	natocrit level equal to 27% with			A Lab log boo boon instituted for b	oth	
	a normai range equ				A Lab log has been instituted for be routine and Stat Labs. This Lab log		
	A review of the Phy	vsician ' s Orders revealed an			reviewed in the morning Clinical M		
	-	14 which stated "Repeat			by the DON and Nurse Managers		
		ount and Basic Metabolic			compliance.		
	Panel in the mornir				All licensed staff have been reedu		
					by the DON in the use of the Lab lo	og	
		onducted with Administrative			system between 12/29/2014 and		
		4 at 10:11 AM. She stated the			01/02/2015. The Medical records clerk has bee	n	
		wn on 11/27/14 and sent to the mediate evaluation and the			reeducated by the DON on 12/18/1		
		becimen to another laboratory			regarding proper thinning of charts		
		stated Administrative Staff #4			missing Lidocaine patch was a res		
		aboratory on more than one			improper thinning of orders.		
		ested the lab results to be sent			All Licensed staff has been reeduc	ated	

Facility ID: 952941

If continuation sheet Page 2 of 10

		& MEDICAID SERVICES					0938-039
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 345051		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			B. WING			C 12/17/2014	
NAME OF	PROVIDER OR SUPPLIER	·		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ANSON	HEALTH AND REHAB	BILITATION			05 SOUTH GREENE STREET /ADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIOI DATE
F 309	to the facility. She s unable to obtain the not indicate there w facility staff to follow she expected the re be received by the after being sent for 2. Resident #84 w 3/25/13. Diagnose and chronic compla A Quarterly Minimu 11/24/14 indicated intact. The assess scheduled pain me receive any prn (as during the assess an order dated 10/2 (patch used to relief	stated the facility had been e laboratory results. She did was a specific process for the w up on lab results. She stated esults for labs ordered stat to facility within twenty-four hours revaluation. as admitted to the facility s included: arthritis of knees aints of pain. Im Data Set (MDS) dated Resident #84 was cognitively ment noted that she was on dication regime and did not a needed) pain medication nent period. s were reviewed and revealed 24/14 for " Lidoderm patch eve pain at the area on which it	F 3	09	regarding the proper transcription of Medications between 12/18/2014 to 12/31/2014 by the DON and Clinical Managers. All new licensed staff will be in service during their orientation period regard these two procedures. Monitoring The DON and/or her Nurse Manager review the Lab log on a daily basis in morning Clinical meeting in an ongoin basis. Results brought by the DON, will be reviewed in the monthly Quality Assu Performance Improvement (QAPI) meeting for 2 months for any further recommendations. Any recommendar will be the responsibility of the DON to carry out as per the committee. The DON and/or her Nurse Manager	ing rs will the ng trance ations to rs will	
	A review of the Nov and the November Record (MAR) reve Lidoderm patch wa November physicia transcribed to the N documentation that Lidoderm patch for (30 days). On 12/15/14 at 3:5 was not having any chronic pain in her to arthritis. She sta	hours, off 12 hours. " vember 2014 physician orders Medication Administration ealed the order for the is not transcribed to the in orders and was not MAR. There was no t Resident #84 received the the entire month of November 4PM, Resident #84 stated she v pain at this time but she had legs and generalized pain due ated the pain was mostly in her she could not walk due to the			review 100% of the charts for transcr errors for 2 months and then 50% of MARS for 2 months and then random thereafter. Results will be reported by DON to the QAPI committee for 3 mo for further recommendations by the committee. The DON will be respons to carry out any further recommendation	the nly y the onths sible	

If continuation sheet Page 3 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED	
		345051	B. WING			_ 17/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ANSON I	HEALTH AND REHAB	ILITATION		405 SOUTH GREENE STREET WADESBORO, NC 28170		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
F 309	Continued From pa	ge 3	F 30	9		
	pain and arthritis in	-				
	On 12/16/14 at 3:30 stated there were tw month physician ord nurses check both 1 MARS on two differ #1 noted that the or checked on 10/28/1 the second check. signed by the family 11/12/14. She said follow physician ord transcribed the order the November phys MAR. The Lidoder administered as ord On 12/17/14 at 10:1	OPM., Administrative staff #1 vo checks for the end of the ders and MARS. She said two the physician orders and ent days. Administrative staff ders for November were 4 and no signature noted for The physician orders were 7 nurse practitioner on she expected nursing staff to lers and they should have er for the Lidoderm patch to ician order and the November of patch should have been dered.				
F 371 SS=E	resident # 84 did no for the month of No nursing staff would Lidoderm patch as 10/24/14. 483.35(i) FOOD PF	tated she was unaware that of receive her Lidoderm patch vember and expected that have administered the ordered by the physician on ROCURE, /SERVE - SANITARY	F 37	1		1/5/15
	considered satisfac authorities; and	om sources approved or tory by Federal, State or local distribute and serve food litions				

Facility ID: 952941

If continuation sheet Page 4 of 10

PRINTED: 01/21/2015

	-	AND HUMAN SERVICES			PRINTED: FORM A OMB NO.	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMF	SURVEY
		345051	B. WING _		C 12/1	; 7/2014
NAME OF I	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP C	DDE	
ANSON HEALTH AND REHABILITATION			405 SOUTH GREENE STREET WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 4	F 37	71		
		NT is not met as evidenced				
	interview, the facilit dishwashing machi the wash temperati	eview, observation and staff y failed to operate the ne properly in order to reach ure at 150 degrees Fahrenheit se temperature at 180 is included:		F371 The facility procures food fro approved or considered sati the State and Local authoriti prepares, and distributes the sanitary conditions.	sfactory by es and stores,	
	machine was obser	1:15 AM, the dishwashing ved with the administrative ietary Aide #1 was observed to		Corrective Action The Service company inspe	cted and	
	turn on the dishwas that the temperatur few minutes. The r 11:15 AM through 1 temperature was 12 rinse temperature w	shing machine. She stated es would start to go up after a machine was observed from 1:45 AM, and the wash 22 degrees F and the final vas 148 degrees F. At 11:46		serviced the dishmachine 1 and found both rinse tanks v properly and all temps looke Staff responsible for operatii dishwasher have been reed proper operation of the equi	2/19/2014 were heating ed good. ng the ucated in the pment. The	
	and stated that the more than 150 deg degrees for the rins observed from 11:5 the wash temperation	I started to turn another knob temperatures would go up to rees for the wash and 180 se. The machine was again 0 AM through 12:00 noon and ure was 132 degrees F and the ure was 158 degrees. Dietary		temperature log is being use washing and monitored and the Dietary Manager or her a daily. All Mighty Shakes were rem nursing refrigerators and dis Dietary Manager 12/17/2014	d reviewed by assistant oved the carded by the	
	Aide #1 further stat to the dishwashing on how to operate i Aide #2 was the pe	ed that she was just assigned machine and was still learning t. She indicated that Dietary rson who was familiar with the buld come at 4:00 PM.		Corrective Action for those v potential to be effected All residents have the poten	vith the tial to be	
	was interviewed. S working at the facili indicated that she v problem with the di	5 PM, administrative staff #2 the stated that she just started ty about a week ago. She vas told that there was a shwashing machine and the ered. It was the first		affected by this alleged defic All nursing refrigerator in the inspected for any undated so including Mighty shakes by t Manager 12/27/2014. No oth dietary product was found.	e facility were upplements, he Dietary	
		wash), the tray would not move		Systemic Changes		

Facility ID: 952941

If continuation sheet Page 5 of 10

CENTERS FOR MEDICAR TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	Сом	E SURVEY PLETED	
345051		B. WING _			C 12/17/2014	
NAME OF PROVIDER OR SUPPLIER ANSON HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170			
PREFIX (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) COMPLETIC DATE	
forward. Administ that there was a p machine temperat F for the wash and rinse but she was On 12/17/14 at 5:' was again observed observed to turn of final rinse temperat On 12/17/14 at 5:4 was interviewed. the dishwashing n problem with the t thought the proble how to properly op that he will educat the machine in the The dish machine reviewed. Admini find the temperatu September and O 2014 log revealed order from Novem and paper produci 2014 log revealed December 1 throu	<ul> <li>anually push the tray to move rative staff #2 acknowledged roblem with the dishwashing ures not reaching 150 degrees 180 degrees F for the final not aware of the problem.</li> <li>15 PM, dishwashing machine ed. Dietary Aide #2 was n the machine. At 5:30 PM, the ature was 150 degrees F.</li> <li>15 PM, administrative staff #3 He stated that he had checked hachine and there was no emperatures. He added that he m was the staff did not know berate the machine. He stated e the staff on how to operate e morning.</li> <li>temperature logs were strative staff #2 was not able to re log for the month of ctober, 2014. The November, that the machine was out of ber 24 through December 1st as were used. The December, no temperatures recorded from gh 11.</li> </ul>	F 37	<ul> <li>Dietary staff, including the Dieta Manager, have been reeducated Maintenance Director on 12/18, proper operation of the dishwas including monitoring and docum of temperatures. The Dietary M has been reeducated in the pro- of dietary products by the Admi 12-18-14.</li> <li>Monitoring</li> <li>The Dietary Manager will utilize Audit tool to monitor proper rins dishwasher, proper use of the dishwasher, and proper dating products. This tool will be used basis for 2 weeks, then weekly weeks, then monthly x 2 month results will be reported by the D Manger to the monthly QAPI co 3months for any further recommendations. The Dietary and the Administrator will the ref for carrying out any further recommendations by the comm</li> </ul>	d by the /14 to the sher, nentation anager per dating nistrator on a Dietary se temps of of the food on a daily for 2 s. The Dietary ommittee x Manager esponsible		

If continuation sheet Page 6 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 01/21/2015 APPROVED . 0938-0391
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345051	B. WING				0 17/2014
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ANSON H	HEALTH AND REHAB	ILITATION			105 SOUTH GREENE STREET NADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 371 F 431 SS=D	observed. There w shakes observed w shakes were observed W Shakes were observed W On 12/17/14 at 2:50 #2 (dogwood and s There were five car with no sticker/date On 12/17/14 at 4:20 was interviewed. S told that she was re nourishment refrige snacks/supplement that it was her fault on the great shakes nourishment refrige facility ' s policy was 14 days after they w 483.60(b), (d), (e) D LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in a accurate reconciliat reconds are in order controlled drugs is n reconciled. Drugs and biological labeled in accordan professional princip	<ul> <li>gnolia and rose halls) was ere four cartons of great ith no date on them. The ved to have been thawed.</li> <li>D PM, nourishment refrigerator unflower halls) was observed. tons of great shakes observed tons of great shakes observed.</li> <li>D PM, administrative staff #2 he stated that she was just esponsible for checking the erator for expired to products. She also stated for not putting the sticker/date is when she put them in the erator. She added that the sto discard the great shakes vere placed in the refrigerator. DRUG RECORDS, UGS &amp; BIOLOGICALS</li> <li>nploy or obtain the services of cist who establishes a system t and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically</li> </ul>		431			1/5/15
	was interviewed. S told that she was re- nourishment refrige snacks/supplement that it was her fault on the great shakes nourishment refrige facility 's policy was 14 days after they w 483.60(b), (d), (e) E LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in a accurate reconciliat records are in order controlled drugs is n reconciled. Drugs and biological labeled in accordan	he stated that she was just esponsible for checking the erator for expired products. She also stated for not putting the sticker/date swhen she put them in the erator. She added that the sto discard the great shakes were placed in the refrigerator. DRUG RECORDS, UGS & BIOLOGICALS holoy or obtain the services of cist who establishes a system t and disposition of all sufficient detail to enable an cion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted les, and include the	F۷	431			1/5/15

Facility ID: 952941

If continuation sheet Page 7 of 10

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
						С	
		345051	B. WING			12/1	17/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTH GREENE STREET		
ANSON	HEALTH AND REHAB	ILITATION			ADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	instructions, and the applicable. In accordance with facility must store a locked compartmer controls, and permi have access to the The facility must pro- permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except wher package drug distri	e expiration date when State and Federal laws, the Il drugs and biologicals in its under proper temperature t only authorized personnel to keys. ovide separately locked, I compartments for storage of red in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can	F 4:	31			
	by: 0431 Based on observati interviews, the facili multi-dose vials of i multi-dose vial of N one of two medicati date one Ventolin in findings included: 1. Manufacturer ' s influenza vaccine 2 part, " 16.2 storage stopper of the multi	NT is not met as evidenced on, record review and staff ity failed to date three opened nfluenza vaccine and one ovolin 70/30 insulin located in ion refrigerators and failed to shaler when opened. The instructions for Afluria 014-2015 formula stated, in and handling. Once the -dose vial has been pierced, carded within 28 days ".			F431 The drugs and biologicals used in the facility are labeled in accordance with currently accepted professional print Corrective action The undated multidated vials of Flut vaccine, one insulin vial, and Vental inhaler were removed and discarded the DON at the time of survey. Corrective Action for those with the potential to be effected	ith nciples. lin	

Facility ID: 952941

If continuation sheet Page 8 of 10

PRINTED: 01/21/2015

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		```			COM	OATE SURVEY OMPLETED C	
345051		B. WING	B. WING			12/17/2014		
	(EACH DEFICIENC)	SILITATION ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	4 V	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTH GREENE STREET VADESBORO, NC 28170 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	I BE	(X5) COMPLETIO DATE	
F 431	<ul> <li>medication refrigeration revealed three vials of Afluria influe</li> <li>On 12/17/14 at 11:4</li> <li>both stated the politimulti-dose vials why vaccine should have opened.</li> <li>On 12/17/14 at 11:5</li> <li>stated nursing staff should have dated was opened.</li> <li>2. Manufacturer 's insulin reads, in parvial after six (6) we there is insulin left if On 12.17.14 at 11:4</li> <li>medication refrigeration refrigeration revealed one Novolin 70/30 insul On 12/17/14 at 11:4</li> <li>both stated the politimulti-dose vials why should have been of On 12/17/14 at 11:4</li> </ul>	48AM, an observation of the ator in the main medication e (3) opened and undated enza vaccine. 48AM, Nurse #1 and Nurse #2 icy of the facility was to date all en opened and the influenza re been dated when it was first 55AM, Administrative staff #1 f should follow the policy and the influenza vaccine when it s instructions for Novolin 70/30 rt, " Throw away an opened eks (42 days) of use, even if in the vial " . 48AM, an observation of the ator in the main medication opened and undated vial of	F 4	.31	DEFICIENCY) At the time of notification of an undar medicine, an audit of all med rooms med carts was performed by the DO her Assistant Director of Nursing, and two RN unit managers on 12/17/207 Any undated items found were correct at that time. Systemic Changes All Licensed staff have been reedur regarding proper dating of medication between 12/17/2014 and 12/31/2017 the DON. All new licensed staff will be educated regarding labeling and dating medication during their orientation period. Monitoring Medications, including med carts ar rooms, will be inspected daily by the or her RN Supervisor, x 2 weeks ar weekly x 2 weeks and then monthly months. Results of monitoring will be reported by the DON to the monthly meeting. Any further recommendation the DON to carry out.	cated ons 4 by ed cations d med e DON nd x3 ee y QAPI ons by		

Facility ID: 952941

If continuation sheet Page 9 of 10

		AND HUMAN SERVICES			FORM	01/21/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C	
		345051	B. WING			0 17/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ANSON	HEALTH AND REHAB	ILITATION		105 SOUTH GREENE STREET NADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 431	Ventolin HFA Inhala 2012 was reviewed HFA inhaler away a shows 000, after the Ventolin HFA packa open the foil pouch. On 12/17/14 at 11:4 Dogwood medicatic and undated ventol An interview was co 12/17/14 at 12:00 F were expected to m with the date opene An interview was co Staff #1 on 12/17/14 nursing staff was no inhalers with the da nursing staff was exp	er's Patient Information for ation Aerosol dated October I. It stated "Throw the Ventolin is soon as the dose counter e expiration date on the aging, or 12 months after you , whichever comes first. " 45 AM an observation of the on cart revealed one opened in inhaler. onducted with Nurse #1 on PM. She stated the nurses nark all multi-dose medications	F 431			

Facility ID: 952941

If continuation sheet Page 10 of 10