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

PRINTED: 02/26/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345155	B. WING		C 02/04/2016	
	ROVIDER OR SUPPLIER  PH HEALTH AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  230 EAST PRESNELL STREET  ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 356 SS=C	INFORMATION  The facility must pos a daily basis: o Facility name. o The current date. o The total number a by the following cate unlicensed nursing s resident care per sh - Registered nur - Licensed practi vocational nurses (a - Certified nurse o Resident census.  The facility must pos specified above on a of each shift. Data r o Clear and readable o In a prominent pla residents and visitor  The facility must, up make nurse staffing for review at a cost r standard.  The facility must ma staffing data for a m required by State law  This REQUIREMEN by: Based on record rev	and the actual hours worked agories of licensed and staff directly responsible for lift: ses. cal nurses or licensed s defined under State law). aides.  at the nurse staffing data a daily basis at the beginning must be posted as follows: format. ce readily accessible to s. on oral or written request, data available to the public mot to exceed the community intain the posted daily nurse inimum of 18 months, or as any, whichever is greater.  T is not met as evidenced view and staff interviews, the the current nurse staffing	F 35	,		
APODATODVI		/SUPPLIER REPRESENTATIVE'S SIGNATUR		be missing.	(X6) DATE	

Electronically Signed

02/18/2016

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED
		345155	B. WING _		C 02/04/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/04/2010
				230 EAST PRESNELL STREET	
RANDOLPH HEALTH AND REHABILITATION CENTER				ASHEBORO, NC 27203	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 356	1.3	e 1 aff form dated 1/21/16 was	F 3	56 2) The Nurse Staffing Information	tion will be
	observed to be posted on the wall of the main lobby on 2/1/16 at 11:15 AM.  An interview was conducted with Administrative Staff #1 on 2/1/16 at 11:30 AM. She stated she			posted daily by a member of the Department or their designee, a of the department head team.	member
				<ol> <li>The Scheduler and the Wee Supervisor were in serviced on t</li> </ol>	
	expected Office Staff Nursing Staff form ev	#1 to post the current Daily ery morning.		importance of posting the Nurse Information on February 12 and	•
	on 2/4/16 at 9:52 AM expected to post the	current Daily Nursing Staff		<ul><li>13.</li><li>4) The Posting of the Nurse States</li><li>Information will be monitored by and the Administrator or designed</li></ul>	the DON ee, a
	form every morning. S remember to post the	She stated she did not current form.		member of the department head QA and reported in the QA meet least 3 months.  5) Completion Date February	tings for at
				5) Completion Date residary	10, 2010