STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies weree citedas a result of the complaint investigatin conduted on 8/11/16 Event ID E2H611. Intake # NC00119681.	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review the facility failed to maintain wheel chairs that were clean and in good repair for 3 of 3 residents' wheelchairs observed for environmental concerns (Residents #42, #109 & #110). The findings included: 1. Resident #42 was admitted on 3/4/10 with diagnoses which included congestive heart failure, hypertension, diabetes, stroke, chronic obstructive pulmonary disease and atrial fibrillation. His Minimum Data Set (MDS) assessment indicated he was moderately cognitively impaired without behaviors or rejection of care. He required limited assistance with transfers, walking, locomotion, dressing and toilet use. He required extensive assistance with personal hygiene and bathing. He used a wheelchair for mobility. Resident #42 was observed 8/9/16 at 4:11 PM sitting in bed. His wheelchair, located beside his bed, was observed to have a split in the center back of the chair. A black, dry substance was	F 253	Submission of the response to The Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. Criteria 1 The three affected wheelchairs were cleaned/repaired. 8/10/16 Criteria 2 All residents have the potential to be affected by the alleged deficient practice, therefore, a 100% audit was conducted by the Maintenance Director, Housekeeping Supervisor, and Administrator to identify any wheelchairs that need cleaning or repair. All identified wheelchairs were cleaned/repaired. 8/26/16 Criteria 3 A cleaning schedule has been created. Chairs will also be inspected for	8/26/16

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

Electronically Signed | 08/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 253	Continued From page 1 observed on the frame where leg rests could be attached. Resident #42 stated he was not aware of anyone cleaning his wheelchair. An interview was conducted 8/9/16 at 4:17 PM with Nurse #1. She stated any damage or malfunction of equipment should be reported to maintenance using a work order. She stated wheelchairs were usually cleaned by housekeeping staff on second shift. She stated she was not sure how that was scheduled and could not recall anyone cleaning wheelchairs during 7:00 AM to 3:00 PM shift. An interview was conducted on 8/10/16 at 9:00 AM with the Assistant Housekeeping Manager. She stated wheelchairs were cleaned by the floor techs when they were notified by the rehab staff. She added there was a wheelchair cleaning schedule. An interview was conducted on 8/10/16 at 9:43 AM with the Rehab Manager. She stated staff would notify rehab or maintenance if wheelchairs needed repairs. She stated she would notify maintenance if new parts needed to be ordered. She indicated the rehab staff would notify housekeeping if they noticed a wheelchair needed to be cleaned. An interview was conducted on 8/10/16 at 4:17 PM with Nurse #2. She stated housekeeping was responsible for cleaning wheelchairs. She stated she was unaware of how often they were cleaned or when housekeeping did the cleaning. An interview was conducted on 8/10/16 at 4:20 PM with the Housekeeping Manager. He stated the housekeeping and nursing staff notified him when wheelchairs needed to be cleaned or he would make rounds of the facility. He stated when wheelchairs were cleaned, he wrote the room number on a calendar posted in his office. He stated he had been employed at the facility	F 253	repair needs while they are being cleaned. Staff also educated to put any needed repairs on the Maintenance Request Log which will be checked daily. Staff also educated to notify Maintenance Director or Administrator directly if any repairs are needed throughout the day. 8/26/16 Criteria 4 Wheel Chairs will be audited weekly for 4 weeks, then monthly for 2 months and results reported to the facility QAA committee. The Administrator will incorporate the POC into the facility's monthly QAA meeting and report any findings to the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 253	Continued From page 2	F 253		

since April 2016 and was not aware of a system of tracking when and how wheelchairs were cleaned before that time. The housekeeping manager was shown Resident #42 ' s wheelchair. He removed the black substance from the frame with his finger. He stated he was not sure of the last time the wheelchair was cleaned, he would have to check the schedule. He returned to his office and obtained a Wheelchair cleaning schedule dated 3/2/16, a calendar for June 2016 and August 2016. Resident #42's room number was indicated on the March and June schedule as being cleaned one time each month. He stated there was no other documentation found.
An interview was conducted 8/10/16 at 4:38 PM with the Director of Nursing. She stated she thought there was a schedule for cleaning wheelchairs. She added that some needed to be cleaned more often because the residents had difficulty feeding themselves, but didn't want help. She stated if she saw a wheelchair that needed to be cleaned, she would notify one of the floor techs and they would take them out in the courtyard and clean them.
An interview was conducted 8/11/16 at 8:15 AM with the Maintenance Manager. He stated he did not have any documentation of wheelchair maintenance or repairs. He stated he fixed things as he was notified or when he noticed something needed to be fixed. Resident #42's wheelchair was observed in the maintenance office. He stated he had been notified about the torn seat and was going to replace it.
An interview was conducted 8/11/16 at 9:23 AM with the Administrator. He stated housekeeping was responsible for cleaning wheelchairs and reporting any needed repairs to maintenance. He stated the staff was also responsible for reporting any needed repairs they observed while assisting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 3	F 253		

residents into wheelchairs to the maintenance manager.
2. Resident #109 was admitted 7/1/14 with diagnoses which included dementia, anxiety and persistent mood disorder.
The most recent MDS dated 6/7/16 indicated Resident #109 was moderately cognitively impaired, had not behaviors, exhibited rejection of care 1-3 days during the assessment period. He required supervision with set up for eating, extensive assistance with transfers, locomotion and personal hygiene and was totally dependent on staff for bathing.
On 8/9/16 at 4:17 PM, Resident #109 was observed sitting in his wheelchair in the dining area on the 1 west hall. The left arm rest was noted to have a tear approximately 6 inches long with padding material exposed. The right arm rest had multiple small tears. The right wheel and frame were coated in a white, milky substance with food particles.
An interview was conducted 8/9/16 at 4:17 PM with Nurse #1. She stated any damage or malfunction of equipment should be reported to maintenance using a work order. She stated wheelchairs were usually cleaned by housekeeping staff on second shift. She stated she was not sure how that was scheduled and could not recall anyone cleaning wheelchairs during the 7:00 AM to 3:00 PM shift.
On 8/10/16 at 8:15 AM, Resident #109 was observed sitting in his wheelchair in the dining area. The tears were no longer present on the arm rests. The right wheel and frame continued to have a white, milky substance with food particles on it.
An interview was conducted on 8/10/16 at 9:00 AM with the Assistant Housekeeping Manager. She stated wheelchairs were cleaned by the floor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 4	F 253		

techs when they were notified by the rehab staff. She added there was a wheelchair cleaning schedule.
An interview was conducted on 8/10/16 at 9:43 AM with the Rehab Manager. She stated staff would notify rehab or maintenance if wheelchairs needed repairs. She stated she would notify maintenance if new parts needed to be ordered. She indicated the rehab staff would notify housekeeping if they noticed a wheelchair needed to be cleaned.
An interview was conducted on 8/10/16 at 4:17 PM with Nurse #2. She stated housekeeping was responsible for cleaning wheelchairs. She stated she was unaware of how often they were cleaned or when housekeeping did the cleaning.
An interview was conducted on 8/10/16 at 4:20 PM with the Housekeeping Manager. He stated the housekeeping and nursing staff notified him when wheelchairs needed to be cleaned or he would make rounds of the facility. He stated when wheelchairs were cleaned, he wrote the room number on a calendar posted in his office. He stated he had been employed at the facility since April 2016 and was not aware of a system of tracking when and how wheelchairs were cleaned before that time. The housekeeping manager was shown Resident #109's wheelchair. He stated he was not sure of the last time the wheelchair was cleaned, he would have to check the schedule. He returned to his office and obtained a Wheelchair Cleaning Schedule dated 3/2/16, a calendar for June 2016 and August 2016. There was no documentation of Resident #109's wheelchair having been cleaned on the schedules.
An interview was conducted 8/10/16 at 4:38 PM with the Director of Nursing. She stated she thought there was a schedule for cleaning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 253	Continued From page 5	F 253		

wheelchairs. She added that some needed to be cleaned more often because the residents had difficulty feeding themselves but didn't want help. She stated if she saw a wheelchair that needed to be cleaned, she would notify one of the floor techs and they would take them out in the courtyard and clean them.
An interview was conducted 8/11/16 at 8:15 AM with the Maintenance Manager. He stated he did not have any documentation of wheelchair maintenance or repairs. He stated he fixed things as he was notified or when he noticed something needed to be fixed.
An interview was conducted 8/11/16 at 9:23 AM with the Administrator. He stated housekeeping was responsible for cleaning wheelchairs and reporting any needed repairs to maintenance. He stated the staff was also responsible for reporting any needed repairs they observed while assisting residents into wheelchairs to the maintenance manager.
3. Resident #110 was admitted to the facility 8/28/14 with diagnoses which included congestive heart failure, hypertension, diabetes, stroke and anxiety.
His annual MDS dated 7/6/16 indicated he was mildly cognitively impaired with no behaviors and rejection of care occurred 1-3 days during his assessment period. He required extensive assistance with transfer, walking in the room, locomotion on the unit, dressing, eating, toilet use, personal hygiene and bathing. He was noted to use a walker and wheelchair for mobility.
On 8/8/16 at 3:47 PM, Resident #110 was observed sitting in his room in a wheelchair. The vinyl at the front corners of the seat was split in several places. A dried white substance was observed on the right side of the wheel frame.
On 8/9/16 at 4:00 PM, Resident #110 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 6	F 253		

observed sitting in his room in a wheelchair. Tears were noted on the seat where it was attached to the frame. Resident #110 stated he was not aware of anyone cleaning his wheelchair.
An interview was conducted on 8/9/16 at 4:11 PM with Nursing Assistant #1. She stated staff reported torn or broken wheelchairs to maintenance or rehab. She further stated that wheelchairs could be taken to the shower room or outside if they needed to be cleaned. She added the floor techs were responsible for cleaning wheelchairs. She was not sure if there was a schedule for cleaning wheelchairs.
An interview was conducted 8/9/16 at 4:17 PM with Nurse #1. She stated any damage or malfunction of equipment should be reported to maintenance using a work order. She stated wheelchairs were usually cleaned by housekeeping staff on second shift. She stated she was not sure how that was scheduled and could not recall anyone cleaning wheelchairs during the 7:00 AM to 3:00 PM shift.
An interview was conducted on 8/10/16 at 9:00 AM with the Assistant Housekeeping Manager. She stated wheelchairs were cleaned by the floor techs when they were notified by the rehab staff. She added there was a wheelchair cleaning schedule.
On 8/10/16 at 9:08 AM, Resident #110 was observed sitting in his room in a wheelchair. Tears were observed at the corners of the seat and a white substance was noted on the right lower rails in front of the wheels.
An interview was conducted on 8/10/16 at 9:43 AM with the Rehab Manager. She stated staff would notify rehab or maintenance if wheelchairs needed repairs. She stated she would notify maintenance if new parts needed to be ordered. She indicated the rehab staff would notify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 253	Continued From page 7	F 253		

housekeeping if they noticed a wheelchair needed to be cleaned.
An interview was conducted on 8/10/16 at 4:17 PM with Nurse #2. She stated housekeeping was responsible for cleaning wheelchairs. She stated she was unaware of how often they were cleaned or when housekeeping did the cleaning.
An interview was conducted on 8/10/16 at 4:20 PM with the Housekeeping Manager. He stated the housekeeping and nursing staff notified him when wheelchairs needed to be cleaned or he would make rounds of the facility. He stated when wheelchairs were cleaned, he wrote the room number on a calendar posted in his office. He stated he had been employed at the facility since April 2016 and was not aware of a system of tracking when and how wheelchairs were cleaned before that time. The housekeeping manager was shown Resident #110's wheelchair. He stated he was not sure of the last time Resident #110's wheelchair was cleaned but he was familiar with the resident and housekeeping cleaned his room "sometimes 2 to 3 times a day . He returned to his office and obtained a Wheelchair Cleaning Schedule dated 3/2/16, a calendar for June 2016 and August 2016. Resident #110's room number was noted on 6/8/16. He stated he would take the chair now since the resident was not using it and have it cleaned.
An interview was conducted 8/10/16 at 4:38 PM with the Director of Nursing. She stated she thought there was a schedule for cleaning wheelchairs. She added that some needed to be cleaned more often because the residents had difficulty feeding themselves but didn't want help. She stated if she saw a wheelchair that needed to be cleaned, she would notify one of the floor techs and they would take them out in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 253	Continued From page 8 courtyard and clean them. An interview was conducted 8/11/16 at 8:15 AM with the Maintenance Manager. He stated he did not have any documentation of wheelchair maintenance or repairs. He stated he fixed things as he was notified or when he noticed something needed to be fixed. An interview was conducted 8/11/16 at 9:23 AM with the Administrator. He stated housekeeping was responsible for cleaning wheelchairs and reporting any needed repairs to maintenance. He stated the staff was also responsible for reporting any needed repairs they observed while assisting residents into wheelchairs to the maintenance manager.	F 253		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual	F 278		8/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 278	Continued From page 9 to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 10 of 11 residents (Residents # 5,9,14,43,49,62,72,86,109,& 119) reviewed for Level II Preadmission Screening and Resident Review (Level II PASRR, a resident identified as having a serious mental illness or intellectual debility as defined by state and federal guidelines) and for 1 of 3 residents (Resident #142) reviewed for accidents. The findings included: 1. Resident #5 had been admitted on 5/16/2014 with diagnoses including schizophrenia, dementia with behavioral disturbance, depression, hypertension and chronic obstructive pulmonary disease. Review of Resident #5's PASRR information dated 4/11/2013 indicated he had been assessed as having Level II PASRR. Resident #5's most recent Annual MDS assessment dated 12/21/2015 did not indicate Resident had been assessed as Level II PASRR. An interview with the MDS nurse was conducted on 8/10/2016 at 9:15 AM. The MDS nurse stated it had been her responsibility to code the PASRR information on the MDS assessments. The PASRR information would be communicated to her by the social worker. The MDS nurse stated	F 278	Submission of the response to The Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. F 278 ASSESSMENT ACCURACY/ COORDINATION /CERTIFIED Criteria #1 The MDS for residents # 5, 9, 14, 43, 49, 62, 72, 86, 109 and 119 were modified By the MDS Coordinator to reflect the corrected Level II PASRR coding. The MDS for resident # 142 was modified by The MDS Coordinator to reflect the fall on 07/26/16. 8/10/16 Criteria #2 All residents have the potential to be affected by this alleged deficient practice, therefore, a 100% audit was conducted by the MDS Coordinator,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 278	Continued From page 10 many of the residents who were Level II PASRR had been living in the facility for some time and the information had just dropped off along the line. An interview with the Social Worker (SW) was conducted on 8/10/2016 at 9:33 AM. The SW stated Level II PASRR was usually evaluated prior to admission and this information would be placed on the resident's medical record. The SW stated all new admissions were discussed during the morning meetings. The SW indicated Level II PASRR information was noted on the MDS. An interview with the Director of Nursing (DON) was conducted on 8/11/2016 at 8:22 AM. The DON stated she would expect the MDS to be complete and accurate. The DON stated she would expect the different disciplines to communicate with each other to ensure MDS accuracy and Level II PASRR information should be captured on the MDS assessment. 2. Resident #9 had been admitted on 4/21/2000 with diagnoses including depressive disorder, traumatic cerebral hemorrhage, convulsions, chronic obstructive pulmonary disease and hypertension. Review of Resident #9's PASRR information dated 2/05/2007 indicated she had been assessed as having Level II PASRR. Review of Resident #9's most recent Annual MDS assessment dated 3/29/2016 did not indicate she had been assessed as having Level II PASRR. An interview with the MDS nurse was conducted on 8/10/2016 at 9:15 AM. The MDS nurse stated it had been her responsibility to code the PASRR information on the MDS assessments. The PASRR information would be communicated to	F 278	Social Worker, Medical Records Director and the Director of Nursing, of all current residents with a Level II PASRR. A 100% audit of falls was completed by the MDS Coordinator and the Director of Nursing. 8/26/16 Criteria #3 The MDS Coordinator and Social Worker was educated by the Director of Clinical Reimbursement/MDS on the correct coding of MDS in relation to Level II PASRR. The PASRR Level II list will be reviewed weekly during the Clinical Meeting by the Director of Nursing, MDS Coordinator and the Social Services Director to ensure accurate coding of the MDS. To ensure continued compliance, the Social Services Director will review all new Admission FL2 for the PASRR number. The Social Services Director will keep an ongoing list of all resident who are a Level II PASRR. The MDS Coordinator was educated by the Director of Clinical Reimbursement/MDS on the correct coding of falls on the Minimum Data Set. Section J of the MDS will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11 her by the social worker. The MDS nurse stated many of the residents who were Level II PASRR had been living in the facility for some time and the information had just dropped off along the line. An interview with the Social Worker (SW) was conducted on 8/10/2016 at 9:33 AM. The SW stated Level II PASRR was usually evaluated prior to admission and this information would be placed on the resident's medical record. The SW stated all new admissions were discussed during the morning meetings. The SW indicated Level II PASRR information was noted on the MDS. An interview with the Director of Nursing (DON) was conducted on 8/11/2016 at 8:22 AM. The DON stated she would expect the MDS to be complete and accurate. The DON stated she would expect the different disciplines to communicate with each other to ensure MDS accuracy and Level II PASRR information should be captured on the MDS assessment. 3. Resident #14 had been admitted on 3/19/2001 with diagnoses including Bipolar disorder, congestive heart failure and diabetes. Review of Resident #14's PASRR information dated 4/20/2015 indicated she had been assessed as having Level II PASRR. Resident #14's most recent comprehensive MDS assessment dated 12/29/2015 did not indicate she had been assessed as Level II PASRR. 4. Resident #43 had been admitted on 2/07/2007 with diagnoses including paranoid schizophrenia, dementia, borderline personality disorder and psychosis. Review of Resident #43's PASRR information dated 1/31/2008 indicated she had been	F 278	reviewed weekly by the Director of Clinical Reimbursement/ MDS by validating the falls log and querying the MDS for accurate coding of falls. 8/10/16 Criteria # 4 Minimum Data Sets will be audited weekly times 4 weeks, then monthly for 2 months then as determined by the QAA team and by the Director of Clinical Reimbursement/MDS, for accuracy of the MDS coding with regard to the Level II PASRR. The results will be recorded on the Level II PASARR audit tool. The Director of Nursing will incorporate the POC into the facility's monthly QAA and report any significant findings from the follow-up to the QAA team. Minimum Data Sets will be audited weekly for 4 weeks, then monthly for 2 months, then as determined by the QAA team and by the Director of Clinical Reimbursement/MDS, for accuracy of the MDS coding in relation to falls. The Director of Nursing will incorporate the POC into the facility's monthly QAA and report any significant findings from the follow-up to the QAA team. 8/10/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 278	Continued From page 12	F 278		

assessed as having Level II PASRR.
Review of Resident #43's most recent Annual MDS assessment dated 5/20/2016 did not indicate she had been assessed as having Level II PASRR.
An interview with the MDS nurse was conducted on 8/10/2016 at 9:15 AM. The MDS nurse stated it had been her responsibility to code the PASRR information on the MDS assessments. The PASRR information would be communicated to her by the social worker. The MDS nurse stated many of the residents who were Level II PASRR had been living in the facility for some time and the information had just dropped off along the line.

An interview with the Social Worker (SW) was conducted on 8/10/2016 at 9:33 AM. The SW stated Level II PASRR was usually evaluated prior to admission and this information would be placed on the resident's medical record. The SW stated all new admissions were discussed during the morning meetings. The SW indicated Level II PASRR information was noted on the MDS.

An interview with the Director of Nursing (DON) was conducted on 8/11/2016 at 8:22 AM. The DON stated she would expect the MDS to be complete and accurate. The DON stated she would expect the different disciplines to communicate with each other to ensure MDS accuracy and Level II PASRR information should be captured on the MDS assessment.

5. Resident #49 had been admitted on 9/12/2012 with diagnoses including bipolar, post-traumatic stress disorder, mood disorder, generalized anxiety disorder, convulsions and chronic obstructive pulmonary disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 278	Continued From page 13	F 278		

Review of Resident #49's PASRR information dated 12/18/2012 indicated he had been assessed as having Level II PASRR.
Review of Resident #49's most recent Annual MDS assessment dated 7/01/2016 did not indicate he had been assessed as having Level II PASRR.
An interview with the MDS nurse was conducted on 8/10/2016 at 9:15 AM. The MDS nurse stated it had been her responsibility to code the PASRR information on the MDS assessments. The PASRR information would be communicated to her by the social worker. The MDS nurse stated many of the residents who were Level II PASRR had been living in the facility for some time and the information had just dropped off along the line.

An interview with the Social Worker (SW) was conducted on 8/10/2016 at 9:33 AM. The SW stated Level II PASRR was usually evaluated prior to admission and this information would be placed on the resident's medical record. The SW stated all new admissions were discussed during the morning meetings. The SW indicated Level II PASRR information was noted on the MDS.

An interview with the Director of Nursing (DON) was conducted on 8/11/2016 at 8:22 AM. The DON stated she would expect the MDS to be complete and accurate. The DON stated she would expect the different disciplines to communicate with each other to ensure MDS accuracy and Level II PASRR information should be captured on the MDS assessment.

6. Resident #62 had been admitted on 7/13/2016 with diagnoses including depression, anxiety disorder, dementia and chronic obstructive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 278	Continued From page 14	F 278		

pulmonary disease.
Review of Resident #62's PASRR information dated 6/12/2012 indicated she had been assessed as having Level II PASRR.
Review of Resident #62's Admission MDS assessment dated 7/20/2016 did not indicate she had been assessed as having Level II PASRR.
An interview with the MDS nurse was conducted on 8/10/2016 at 9:15 AM. The MDS nurse stated it had been her responsibility to code the PASRR information on the MDS assessments. The PASRR information would be communicated to her by the social worker. The MDS nurse stated many of the residents who were Level II PASRR had been living in the facility for some time and the information had just dropped off along the line.

An interview with the Social Worker (SW) was conducted on 8/10/2016 at 9:33 AM. The SW stated Level II PASRR was usually evaluated prior to admission and this information would be placed on the resident's medical record. The SW stated all new admissions were discussed during the morning meetings. The SW indicated Level II PASRR information was noted on the MDS.

An interview with the Director of Nursing (DON) was conducted on 8/11/2016 at 8:22 AM. The DON stated she would expect the MDS to be complete and accurate. The DON stated she would expect the different disciplines to communicate with each other to ensure MDS accuracy and Level II PASRR information should be captured on the MDS assessment.

7. Resident #72 had been admitted on 1/26/2011 with diagnoses including schizophrenia, persistent affective mood disorder and intellectual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 278	Continued From page 15	F 278		

disability.
Review of Resident #72's PASRR information dated 1/25/2011 indicated she had been assessed as having Level II PASRR.
Resident #72's most recent Annual MDS assessment dated 11/30/2015 did not indicate she had been assessed as Level II PASRR.
An interview with the MDS nurse was conducted on 8/10/2016 at 9:15 AM. The MDS nurse stated it had been her responsibility to code the PASRR information on the MDS assessments. The PASRR information would be communicated to her by the social worker. The MDS nurse stated many of the residents who were Level II PASRR had been living in the facility for some time and the information had just dropped off along the line.

An interview with the Social Worker (SW) was conducted on 8/10/2016 at 9:33 AM. The SW stated Level II PASRR was usually evaluated prior to admission and this information would be placed on the resident's medical record. The SW stated all new admissions were discussed during the morning meetings. The SW indicated Level II PASRR information was noted on the MDS.

An interview with the Director of Nursing (DON) was conducted on 8/11/2016 at 8:22 AM. The DON stated she would expect the MDS to be complete and accurate. The DON stated she would expect the different disciplines to communicate with each other to ensure MDS accuracy and Level II PASRR information should be captured on the MDS assessment.

8. Resident #86 had been admitted on 4/25/2013 with diagnoses including dementia, psychosis, generalized anxiety and hypertension.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 16	F 278		

Review of Resident #86's PASRR information dated 9/06/2013 indicated he had been assessed as having Level II PASRR.
Review of Resident #86's most recent comprehensive MDS assessment dated 3/07/2016 did not indicate he had been assessed as having Level II PASRR.
An interview with the MDS nurse was conducted on 8/10/2016 at 9:15 AM. The MDS nurse stated it had been her responsibility to code the PASRR information on the MDS assessments. The PASRR information would be communicated to her by the social worker. The MDS nurse stated many of the residents who were Level II PASRR had been living in the facility for some time and the information had just dropped off along the line.

An interview with the Social Worker (SW) was conducted on 8/10/2016 at 9:33 AM. The SW stated Level II PASRR was usually evaluated prior to admission and this information would be placed on the resident's medical record. The SW stated all new admissions were discussed during the morning meetings. The SW indicated Level II PASRR information was noted on the MDS.

An interview with the Director of Nursing (DON) was conducted on 8/11/2016 at 8:22 AM. The DON stated she would expect the MDS to be complete and accurate. The DON stated she would expect the different disciplines to communicate with each other to ensure MDS accuracy and Level II PASRR information should be captured on the MDS assessment.

9. Resident #109 had been admitted on 7/01/2014 with diagnoses including dementia, anxiety, persistent mood disorder and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 17	F 278		

hypertension.
Review of Resident #109's PASRR information dated 7/30/2015 indicated he had been assessed as having Level II PASRR.
Resident #109's most recent Annual MDS assessment dated 12/09/2015 did not indicate he had been assessed as having Level II PASRR.
An interview with the MDS nurse was conducted on 8/10/2016 at 9:15 AM. The MDS nurse stated it had been her responsibility to code the PASRR information on the MDS assessments. The PASRR information would be communicated to her by the social worker. The MDS nurse stated many of the residents who were Level II PASRR had been living in the facility for some time and the information had just dropped off along the line.

An interview with the Social Worker (SW) was conducted on 8/10/2016 at 9:33 AM. The SW stated Level II PASRR was usually evaluated prior to admission and this information would be placed on the resident's medical record. The SW stated all new admissions were discussed during the morning meetings. The SW indicated Level II PASRR information was noted on the MDS.

An interview with the Director of Nursing (DON) was conducted on 8/11/2016 at 8:22 AM. The DON stated she would expect the MDS to be complete and accurate. The DON stated she would expect the different disciplines to communicate with each other to ensure MDS accuracy and Level II PASRR information should be captured on the MDS assessment.

10. Resident #119 had been admitted on 2/28/2015 with diagnoses including Alzheimer's disease, dementia, depression, psychosis,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 18	F 278		

anxiety and hypertension.

Review of Resident #119's PASRR information dated 2/24/2015 indicated she had been assessed as having Level II PASRR.
Review of Resident #119's most recent Annual MDS assessment dated 2/09/2016 did not indicate she had been assessed as having Level II PASRR.
An interview with the MDS nurse was conducted on 8/10/2016 at 9:15 AM. The MDS nurse stated it had been her responsibility to code the PASRR information on the MDS assessments. The PASRR information would be communicated to her by the social worker. The MDS nurse stated many of the residents who were Level II PASRR had been living in the facility for some time and the information had just dropped off along the line.

An interview with the Social Worker (SW) was conducted on 8/10/2016 at 9:33 AM. The SW stated Level II PASRR was usually evaluated prior to admission and this information would be placed on the resident's medical record. The SW stated all new admissions were discussed during the morning meetings. The SW indicated Level II PASRR information was noted on the MDS.

An interview with the Director of Nursing (DON) was conducted on 8/11/2016 at 8:22 AM. The DON stated she would expect the MDS to be complete and accurate. The DON stated she would expect the different disciplines to communicate with each other to ensure MDS accuracy and Level II PASRR information should be captured on the MDS assessment.
11. Resident #142 was admitted to the facility on 7/22/16 with diagnoses which included coronary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 278	Continued From page 19	F 278		

artery disease, muscle weakness, anxiety and cirrhosis.

His admission Minimum Data Set (MDS) of 7/29/16 indicated he had poor cognition and his attention fluctuated. He reported feeling tired or having little energy most days. He was noted to have wandering behaviors. He required supervision with transfers, walking in his room and in halls and with locomotion on and off the unit. The fall history of the MDS indicated there had been no falls since his admission.

A review of the nurses notes dated 7/26/16 at 12:38 PM revealed an Interdisciplinary Fall Meeting was held following a fall which occurred on 7/26/16 at 3:00 AM.

An interview was conducted with the MDS nurse on 08/10/2016 at 3:43 PM. She stated when a resident falls, there was an overhead page in the facility and all available personnel responded. She stated she does respond to those pages and also attends the fall huddle or Interdisciplinary Fall Meeting. She stated that a fall occurring on 7/26/16 should have been documented on the Admission 5-Day assessment. She stated it was a coding error.

An interview was conducted 08/10/2016 at 4:38 PM with the Director of Nursing. She stated all available staff responded to any fall occurring in the facility. She explained if a fall occurs at night or in the early morning, it is documented on the 24-hour report which is given to the administration the next morning for the clinical meeting. She stated those meetings include the MDS nurse. She stated she would expect a fall that occurred within the 7-day look back period to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 278	Continued From page 20 be coded on the admission assessment.	F 278		