PRINTED: 08/31/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345510	B. WING _			08/	11/2016
	O NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		BE .	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00			
F 253		KEEPING &	F 2	53			8/26/16
SS=D	The facility must prov	ide housekeeping and s necessary to maintain a					
	by: Based on observation interviews and record maintain wheel chairs good repair for 3 of 3 observed for environmet 42, #109 & #110). The findings included 1. Resident #42 was diagnoses which inclusted failure, hypertension, obstructive pulmonary fibrillation. His Minimum Data Seindicated he was mod without behaviors or required limited assis walking, locomotion, required extensive as hygiene and bathing, mobility. Resident #42 was obsitting in bed. His whole, was observed to	review the facility failed to a that were clean and in residents' wheelchairs mental concerns (Residents:  admitted on 3/4/10 with uded congestive heart diabetes, stroke, chronic y disease and atrial et (MDS) assessment derately cognitively impaired rejection of care. He		( v ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )	Submission of the response to  The Statement of Deficiencie 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 wheelch were cleaned/repaired.  Criteria 2 All residents have the potento be affected by the alleged deficient practice, therefore, a 100% audit was conducted by the Maintenance Directed Housekeeping Supervisor, and Administrator to identify any wheelchathat need cleaning or repair. All identify wheelchairs were cleaned/repaired.  B/26/16  Criteria 3 A cleaning schedule has be created. Chairs will also be inspected.	d. airs 16 tial or, irs fied	
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E		TITLE		(X6) DATE

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

**Electronically Signed** 

08/26/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345510	B. WING			08/	11/2016
	NURSING CENTER		•	91	TREET ADDRESS, CITY, STATE, ZIP CODE 11 WESTERN BOULEVARD ARBORO, NC 27886		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	attached. Resident of anyone cleaning has anyone cleaning has anyone cleaning has anyone cleaning has anyone the malfunction of equipmaintenance using a wheelchairs were us housekeeping staff of she was not sure how could not recall anyone during 7:00 AM to 3:1 An interview was corned anyone the maintenance was schedule. An interview was corned and with the Rehab has added there was schedule. An interview was corned and material was corned and the maintenance if new part of the mousekeeping if they needed to be cleane an interview was corned with Nurse #2. See the maintenance if or clean she was unaware of or when housekeeping any when wheelchairs new ould make rounds of when wheelchairs was room number on a care of the material was any of the material was corned a	the where leg rests could be the the the the the the the the the th	F	253	repair needs while they are being clear Staff also educated to put any needed repairs on the Maintenance Request Lewhich will be checked daily. Staff also educated to notify Maintenance Director Administrator directly if any repairs a 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 faci QAA committee. The Administrator will incorporate the POC into the facility's monthly QAA meeting and report any findings to the committee.	og or are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345510	B. WING			08	/11/2016
	ROVIDER OR SUPPLIER  D NURSING CENTER			STREET ADDRESS 911 WESTERN BO TARBORO, NC			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACI	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOUL B-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 253	of tracking when and cleaned before that manager was shown He removed the bla with his finger. He is last time the wheelchave to check the so office and obtained schedule dated 3/2/ and August 2016. It was indicated on the as being cleaned or stated there was no An interview was cowith the Director of I thought there was a wheelchairs. She as cleaned more often difficulty feeding the She stated if she sabe cleaned, she won techs and they would courtyard and clean An interview was cowith the Maintenance or reportings as he was no something needed to wheelchair was obsoffice. He stated he torn seat and was gan interview was cowith the Administration was responsible for reporting any needed stated the staff was	I was not aware of a system d how wheelchairs were time. The housekeeping in Resident #42's wheelchair. It is substance from the frame stated he was not sure of the hair was cleaned, he would chedule. He returned to his a Wheelchair cleaning 16, a calendar for June 2016 Resident #42's room number a March and June schedule in time each month. He other documentation found. Inducted 8/10/16 at 4:38 PM Nursing. She stated she schedule for cleaning dided that some needed to be because the residents had miselves, but didn't want help. We a wheelchair that needed to all did notify one of the floor did take them out in the them. Inducted 8/11/16 at 8:15 AM we Manager. He stated he did dentation of wheelchair fairs. He stated he fixed tified or when he noticed to be fixed. Resident #42's gerved in the maintenance had been notified about the	F	253			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345510	B. WING	<del> </del>		08/11/2016	
	ROVIDER OR SUPPLIER  O NURSING CENTER	,		STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 253	manager.  2. Resident #109 wadiagnoses which inclipersistent mood dison. The most recent MD: Resident #109 was nimpaired, had not be care 1-3 days during required supervision extensive assistance and personal hygiene on staff for bathing. On 8/9/16 at 4:17 PN observed sitting in hiarea on the 1 west hanoted to have a tear with padding materia had multiple small teframe were coated in with food particles. An interview was corwith Nurse #1. She smalfunction of equipmaintenance using a wheelchairs were using the 7:00 AM to On 8/10/16 at 8:15 A observed sitting in hiarea. The tears were arm rests. The right to have a white, milking particles on it.  An interview was coronal with the Assistant	chairs to the maintenance as admitted 7/1/14 with uded dementia, anxiety and order. So dated 6/7/16 indicated moderately cognitively haviors, exhibited rejection of the assessment period. He with set up for eating, with transfers, locomotion and was totally dependent  M. Resident #109 was so wheelchair in the dining all. The left arm rest was approximately 6 inches long I exposed. The right arm rest ars. The right wheel and a white, milky substance  and with the dining and the with a stated any damage or ment should be reported to work order. She stated utility cleaned by an second shift. She stated withat was scheduled and an e cleaning wheelchairs	F 25				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345510	B. WING		<del> </del>		08/11/2016
	ROVIDER OR SUPPLIER  D NURSING CENTER		,		RESS, CITY, STATE, ZIP CODE N BOULEVARD NC 27886	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE EACH CORRECTIVE ACTION SH IOSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 253	She added there was chedule.  An interview was condaminate in the Rehab would notify rehab on needed repairs. She maintenance if new She indicated the rehousekeeping if the needed to be cleaned. An interview was condaminate in the needed to be cleaned an interview was condaminate in the needed to be cleaned. An interview was condaminate in the needed to be cleaned when housekeep and interview was condaminate in the needed has a she was unaware of or when housekeeping and when wheelchairs would make rounds when wheelchairs was shown the stated he was now wheelchair was cleaned before that manager was shown the stated he was now wheelchair was cleaned a Wheelch was now wheelc	ore notified by the rehab staff. as a wheelchair cleaning anducted on 8/10/16 at 9:43 Manager. She stated staff or maintenance if wheelchairs e stated she would notify parts needed to be ordered. The staff would notify you noticed a wheelchair	F	253			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345510	B. WING _			08/11/2016	
	ROVIDER OR SUPPLIER  NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COE 911 WESTERN BOULEVARD TARBORO, NC 27886	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 253	wheelchairs. She add cleaned more often be difficulty feeding them. She stated if she saw be cleaned, she would techs and they would courtyard and clean to the An interview was consisted with the Maintenance on the Maintenance or repair things as he was not in something needed to the An interview was conswith the Administrator was responsible for constant of the Maintenance or repair things as he was not in something needed to the An interview was conswith the Administrator was responsible for constant of the Maintenance or repair things any needed stated the staff was a any needed repairs the residents into wheeled manager.  3. Resident #110 was 8/28/14 with diagnose heart failure, hypertenanxiety.  His annual MDS date mildly cognitively imprejection of care occur assessment period. I assistance with transflocomotion on the unit use, personal hygiene noted to use a walker On 8/8/16 at 3:47 PM observed sitting in his vinyl at the front corneseveral places. A dried	ded that some needed to be ecause the residents had iselves but didn't want help. It a wheelchair that needed to do notify one of the floor take them out in the hem.  I ducted 8/11/16 at 8:15 AM Manager. He stated he didentation of wheelchair is. He stated he fixed fied or when he noticed be fixed.  I ducted 8/11/16 at 9:23 AM is. He stated housekeeping leaning wheelchairs and repairs to maintenance. He is or esponsible for reporting help observed while assisting hairs to the maintenance.  I admitted to the facility is which included congestive insion, diabetes, stroke and ind 7/6/16 indicated he was aired with no behaviors and is with no behaviors and is required extensive fer, walking in the room, it, dressing, eating, toilet is and wheelchair for mobility. Resident #110 was a room in a wheelchair. The is strong in a wheelchair. The is strong is the was stide of the wheel frame.	F 2	253			

PRINTED: 08/31/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE &	MEDICAID SERVICES			OIVID INO. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	B. WING		08/11/2016
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
TARBORO NURSING CENTER			911 WESTERN BOULEVARD	
TARBORO NORSING CENTER			TARBORO, NC 27886	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE COMPLETION
Tears were noted on attached to the frame was not aware of any An interview was con with Nursing Assistant reported torn or broke maintenance or rehalf wheelchairs could be outside if they needed the floor techs were maintenance. She was schedule for cleaning An interview was con with Nurse #1. She simulfunction of equipming maintenance using a wheelchairs were usu housekeeping staff or she was not sure how could not recall anyor during the 7:00 AM to An interview was con AM with the Assistant She stated wheelchair techs when they were She added there was schedule.  On 8/10/16 at 9:08 Al observed sitting in his Tears were observed	the seat where it was  Resident #110 stated he rone cleaning his wheelchair. ducted on 8/9/16 at 4:11 PM at #1. She stated staff en wheelchairs to b. She further stated that taken to the shower room or d to be cleaned. She added responsible for cleaning is not sure if there was a wheelchairs. ducted 8/9/16 at 4:17 PM restated any damage or ment should be reported to work order. She stated ually cleaned by n second shift. She stated w that was scheduled and me cleaning wheelchairs	F 25	<u> </u>	

She indicated the rehab staff would notify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345510	B. WING			08/	11/2016	
	ROVIDER OR SUPPLIER  D NURSING CENTER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 253	needed to be cleaned. An interview was coopen with Nurse #2. The sponsible for clear she was unaware of or when housekeeping an interview was coopen with the Housek the housekeeping at when wheelchairs would make rounds when wheelchairs work and the stated he had be since April 2016 and of tracking when and cleaned before that manager was shown He stated he was not resident #110's wheelchair Cleaning calendar for June 200 Resident #110's roof 6/8/16. He stated he since the resident work cleaned. An interview was cowith the Director of Meelchairs. She as cleaned more often difficulty feeding the She stated if she say be cleaned, she would be worked to be stated if she say be cleaned, she worked.	noticed a wheelchair and noticed on 8/10/16 at 4:17 She stated housekeeping was ning wheelchairs. She stated how often they were cleaned ing did the cleaning. Inducted on 8/10/16 at 4:20 eeping Manager. He stated individual individ	F	253				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345510	B. WING			08/	11/2016
	ROVIDER OR SUPPLIER  NURSING CENTER		•	911 V	EET ADDRESS, CITY, STATE, ZIP CODE WESTERN BOULEVARD BORO, NC 27886		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	courtyard and clean to An interview was conwith the Maintenance not have any docume maintenance or repail things as he was notified in the Administrator was responsible for coreporting any needed stated the staff was any needed repairs thresidents into wheeled manager.  483.20(g) - (j) ASSES ACCURACY/COORD The assessment must resident's status.  A registered nurse must resident's status.  A registered nurse must resident's status.  A registered nurse must assessment is complete assessment is complete assessment must sign that portion of the assessment in a resubject to a civil mone \$1,000 for each assessment assessment in a resubject to a civil mone \$1,000 for each assessment assessment assessment in a resubject to a civil mone \$1,000 for each assessment assessment assessment assessment in a resubject to a civil mone \$1,000 for each assessment assessment assessment assessment assessment as a civil mone \$1,000 for each assessment assessment assessment as a civil mone \$1,000 for each assessment assessment assessment as a civil mone \$1,000 for each assessment assessment as a civil mone \$1,000 for each assessment assessment as a civil mone \$1,000 for each assessment assessment as a civil mone \$1,000 for each assessment assessment as a civil mone \$1,000 for each assessment assessment as a civil mone \$1,000 for each assessment as a civil mone	mem. ducted 8/11/16 at 8:15 AM Manager. He stated he did intation of wheelchair rs. He stated he fixed fied or when he noticed be fixed. ducted 8/11/16 at 9:23 AM r. He stated housekeeping leaning wheelchairs and repairs to maintenance. He lso responsible for reporting ney observed while assisting hairs to the maintenance  SSMENT VINATION/CERTIFIED  It accurately reflect the  ust conduct or coordinate in the appropriate professionals.  Just sign and certify that the eted.  completes a portion of the in and certify the accuracy of		253			8/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		345510	B. WING	<del> </del>	08/11/2016
	ROVIDER OR SUPPLIER  NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	,
(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 COMPLETION
F 278	Continued From pag	e 9 and false statement in a	F 27	78	
		is subject to a civil money			
	Clinical disagreemer material and false sta	nt does not constitute a atement.			
	by: Based on record reviage facility failed to accur Data Set (MDS) for 1 # 5,9,14,43,49,62,72 Level II Preadmissio Review (Level II PAS having a serious medebility as defined by guidelines) and for 1 #142) reviewed for a The findings included 1. Resident #5 had by with diagnoses included with diagnoses included this personal disturbance of the serious of the serious of the serious and challed disease. Review of Resident is	of 3 residents (Resident ccidents. d: eeen admitted on 5/16/2014 ding schizophrenia, dementia rbance, depression, ronic obstructive pulmonary #5's PASRR information cated he had been assessed ASRR.		Submission of the response to The Statement of Deficien the undersigned does not constitute an admission th the deficiencies existed, th they were cited correctly, of that any correction is requ  F 278 ASSESSMENT ACCURACY COORDINATION /CERTIFIED Criteria #1 The MDS for residents #14, 43, 49, 62, 72, 86, 109 and 119 we modified By the MDS Coordinator to reflect to corrected Level II PASRR coding.  The MDS for resident # 142 was m	the
	assessment dated 1: Resident had been a An interview with the on 8/10/2016 at 9:15 it had been her respond information on the M PASRR information of	2/21/2015 did not indicate assessed as Level II PASRR. MDS nurse was conducted AM. The MDS nurse stated ansibility to code the PASRR DS assessments. The avould be communicated to aker. The MDS nurse stated		by The MDS Coordinator to reflect the on 07/26/16.  Criteria #2 All residents have the potential to be affected by this alleg deficient practice, therefore, a 1009 was conducted by the MDS Coordi	e fall ged % audit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345510	B. WING _		<del></del>	08,	/11/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
				91′	1 WESTERN BOULEVARD		
TARBORC	NURSING CENTER			TA	ARBORO, NC 27886		
(X4) ID PREFIX TAG	(EACH DEFICIENC	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)		(X5) COMPLETION DATE
F 278	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		F2	F 278 Social Worker, Medical Records			
		e facility for some time and ust dropped off along the			and the Director of Nursing, of all curre residents with a Level II PASRR.		
	conducted on 8/10/2	Social Worker (SW) was 016 at 9:33 AM. The SW R was usually evaluated			A 100% audit of falls was completed by the MDS Coordinator and the Director of Nursing 8/26/16		
	prior to admission ar placed on the reside stated all new admis the morning meeting	nd this information would be nt's medical record. The SW sions were discussed during s. The SW indicated Level II			Criteria #3 The MDS Coordinator and Social Worker was educated by the Director of	of	
	An interview with the was conducted on 8/DON stated she wou complete and accura would expect the diff communicate with ea	was noted on the MDS.  Director of Nursing (DON)  11/2016 at 8:22 AM. The  ald expect the MDS to be  ate. The DON stated she ferent disciplines to  ach other to ensure MDS  II PASRR information should			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 Directof Nursing, MDS Coordinator and the Society	ctor	
	be captured on the N  2. Resident #9 had b with diagnoses include traumatic cerebral he				Services Director to ensure accurate coding of the MDS. To ensure continued compliance, the Social Services Director will review new Admission FL2 for the PASRR number	all	
	dated 2/05/2007 indicassessed as having Review of Resident assessment dated 3/had been assessed An interview with the on 8/10/2016 at 9:15 it had been her response.	Level II PASRR. #9's most recent Annual MDS /29/2016 did not indicate she as having Level II PASRR. #MDS nurse was conducted AM. The MDS nurse stated possibility to code the PASRR			The Social Services Director will keep an ongoing list of all resident who are a Level II PASRR. The MDS Coordinator was educated b the Director of Clinical Reimbursement/MD on the correct coding of falls on the		
		DS assessments. The would be communicated to			Minimum  Data Set. Section J of the MDS will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345510	B. WING			08/	11/2016
NAME OF P	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	20.10
				91	11 WESTERN BOULEVARD		
TARBORG	NURSING CENTER			T/	ARBORO, NC 27886		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 278	Continued From pag	ge 11	F	278			
		rker. The MDS nurse stated			reviewed		
		ts who were Level II PASRR			weekly by the Director of Clinical		
	_	e facility for some time and			Reimbursement/		
		just dropped off along the			MDS by validating the falls log and		
	line.	, , , , ,			querying		
					the MDS for accurate coding of falls.		
	An interview with the	e Social Worker (SW) was			8/10/16		
		2016 at 9:33 AM. The SW					
	I .	RR was usually evaluated			Criteria # 4 Minimum Data Sets will be		
	T	nd this information would be			audited weekly times 4 weeks, then		
	•	ent's medical record. The SW			monthly		
		ssions were discussed during			for 2 months then as determined by the	<del>,</del>	
		gs. The SW indicated Level II			QAA		
	PASRR Information	was noted on the MDS.			team and by the Director of Clinical Reimbursement/MDS, for accuracy of	the	
		e Director of Nursing (DON)			MDS coding with regard to the Level II		
		/11/2016 at 8:22 AM. The			PASRR. The results will be recorded o	n	
		uld expect the MDS to be			the Level II PASARR audit tool. The		
	1	ate. The DON stated she			Director of Nursing will incorporate the		
	would expect the dif	ach other to ensure MDS			POC into the facility's monthly QAA an report any significant findings from the	J	
	I .	II PASRR information should			follow-up to the QAA team.		
	be captured on the I				iollow-up to the QAA team.		
	as supraise on the				Minimum Data Sets will be audited we	ekly	
	3. Resident #14 had	been admitted on 3/19/2001			for 4 weeks, then monthly for 2 months		
	with diagnoses inclu	ding Bipolar disorder,			then		
	congestive heart fail	ure and diabetes.			as determined by the QAA team and b	y	
	Review of Resident	#14's PASRR information			the		
		icated she had been			Director of Clinical Reimbursement/MD	)S,	
	assessed as having				for		
	I .	t recent comprehensive MDS			accuracy of the MDS coding in relation	to	
		2/29/2015 did not indicate			falls.		
		sed as Level II PASRR.			The Director of Nursing will incorporate	;	
		been admitted on 2/07/2007 ding paranoid schizophrenia,			the POC	ort	
	_	e personality disorder and			into the facility's monthly QAA and repo	л	
	psychosis.	personality disorder and			any significant findings from the follow-up to	,	
	' '	#43's PASRR information			the QAA team. 8/10/16	•	
		icated she had been			5/10/10		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BU		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345510	B. WING		08/11/2016
	ROVIDER OR SUPPLIER  NURSING CENTER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 278	MDS assessment dindicate she had be il PASRR.  An interview with the on 8/10/2016 at 9:19 it had been her respinformation on the NPASRR information her by the social wo many of the residen had been living in the information had line.  An interview with the conducted on 8/10/2 stated Level II PASP prior to admission a placed on the reside stated all new admission and placed on the reside stated all new admission and placed on the reside stated all new admission and placed on the reside stated all new admission and placed on the reside stated all new admission.  An interview with the was conducted on 80 DON stated she woo complete and accur would expect the difficommunicate with eaccuracy and Level be captured on the 15. Resident #49 had with diagnoses inclustress disorder, model in the side of the si	Level II PASRR.  #43's most recent Annual ated 5/20/2016 did not en assessed as having Level  MDS nurse was conducted to AM. The MDS nurse stated consibility to code the PASRR MDS assessments. The would be communicated to rker. The MDS nurse stated at who were Level II PASRR are facility for some time and just dropped off along the  Social Worker (SW) was 2016 at 9:33 AM. The SW RR was usually evaluated and this information would be ent's medical record. The SW assions were discussed during as. The SW indicated Level II was noted on the MDS.  Director of Nursing (DON) 1/11/2016 at 8:22 AM. The auld expect the MDS to be ate. The DON stated she are the modern of the m	F 278		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345510	B. WING			08/11/2016	
	ROVIDER OR SUPPLIER  O NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 278	dated 12/18/2012 incomessessed as having Review of Resident: MDS assessment daindicate he had been PASRR. An interview with the on 8/10/2016 at 9:15 it had been her respinformation on the MPASRR information where by the social wormany of the resident had been living in the the information had j line.  An interview with the conducted on 8/10/2 stated Level II PASR prior to admission ar	#49's PASRR information dicated he had been	F 2	78			
	the morning meeting PASRR information of PASRR information of the Mass conducted on 8. DON stated she would expect the difficommunicate with eaccuracy and Level be captured on the Mass conducted on	ach other to ensure MDS II PASRR information should					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345510	B. WING _			08/11/2016	
	ROVIDER OR SUPPLIER  NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP C 911 WESTERN BOULEVARD TARBORO, NC 27886			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 278	dated 6/12/2012 in assessed as having Review of Resider assessment dated had been assessed. An interview with the on 8/10/2016 at 90 it had been her resinformation on the PASRR information her by the social womany of the reside had been living in the information haline.  An interview with the conducted on 8/10 stated Level II PAS prior to admission placed on the reside stated all new admitted the morning meeting PASRR information.  An interview with the was conducted on DON stated she were complete and accurate with accuracy and Level be captured on the with diagnoses incomplete and agnoses incomplete incompl	·	F 2	78			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345510	B. WING			8/11/2016	
	ROVIDER OR SUPPLIER  D NURSING CENTER		91	TREET ADDRESS, CITY, STATE, ZIP CODE 11 WESTERN BOULEVARD ARBORO, NC 27886	•		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 278	dated 1/25/2011 indices assessed as having Resident #72's most assessment dated 1 she had been assess An interview with the on 8/10/2016 at 9:18 it had been her resp information on the MPASRR information her by the social wo many of the resident had been living in the information had line.  An interview with the conducted on 8/10/2 stated Level II PASF prior to admission at placed on the reside stated all new admist the morning meeting PASRR information  An interview with the was conducted on 8 DON stated she wou complete and accurate would expect the difficommunicate with eaccuracy and Level be captured on the M8. Resident #86 had	#72's PASRR information icated she had been Level II PASRR. It recent Annual MDS 1/30/2015 did not indicate sed as Level II PASRR. It may be a more than the	F 278				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '			(X3) DATE SURVEY COMPLETED	
	345510	B. WING	<del> </del>		08/11/2016	
			STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	•		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE	
Review of Resident dated 9/06/2013 ind as having Level II P/Review of Resident comprehensive MDS 3/07/2016 did not in as having Level II P/An interview with the on 8/10/2016 at 9:19 it had been her resp information on the MPASRR information her by the social wo many of the residenthad been living in the information had line.  An interview with the conducted on 8/10/2 stated Level II PASP prior to admission at placed on the residenthal the morning meeting PASRR information  An interview with the was conducted on 8 DON stated she work complete and accurate with eaccuracy and Level be captured on the II.	#86's PASRR information icated he had been assessed ASRR. #86's most recent S assessment dated dicate he had been assessed ASRR.  MDS nurse was conducted ASRR.  MDS nurse was conducted as AM. The MDS nurse stated consibility to code the PASRR IDS assessments. The would be communicated to river. The MDS nurse stated as who were Level II PASRR is the facility for some time and it is information would be and this information would be ent's medical record. The SW is insigned at 9:33 AM. The SW is insigned at 12 AM. The SW indicated Level II was noted on the MDS.  Director of Nursing (DON) 11/1/2016 at 8:22 AM. The ald expect the MDS to be ate. The DON stated she ferent disciplines to ach other to ensure MDS II PASRR information should MDS assessment.	F 2'	78			
	Continued From page Review of Resident dated 9/06/2013 ind as having Level II P/Review of Resident comprehensive MDS 3/07/2016 did not ind as having Level II P/An interview with the on 8/10/2016 at 9:18 it had been her respinformation on the MPASRR information her by the social wo many of the resident had been living in the information had line.  An interview with the conducted on 8/10/2 stated Level II PASE prior to admission an placed on the reside stated all new admiss the morning meeting PASRR information  An interview with the was conducted on 8 DON stated she woo complete and accura would expect the diff communicate with eaccuracy and Level be captured on the MPASE PRESIDENT CONTRIBUTION OF THE PASE P	A 345510  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 16  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	A BUILDING  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 16  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 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,	A BUILDING  345510  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPOIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 16  Review of Resident #86's PASRR information dated 90'60'2013 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,	A BUILDING  34510  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  11 WESTERN BOULEVARD  TARBORO, NC 27866  SUMMARY STATEMENT OF DETICIENCIES  SUMMARY STATEMENT OF DETICIENCIES  SUMMARY STATEMENT OF DETICIENCIES  CECAL DETICIENCY MUST BE PRECEDED BY FILL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 16  Review of Resident #86's PASRR information dated 3706/2013 indicated he had been assessed as having Level II PASRR.  Review of Resident #86's most recent comprehensive MDS assessment dated 307/2016 did not indicate he had been assessed as having Level II PASRR. An interview with the MDS nurse was conducted on 81'0/2016 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 81/10/2016 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 Level II PASRR was usually evaluated prior to admission and this information would be placed on the resident's medical record. The SW stated Level II PASRR was usually evaluated prior to admission 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.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345510	B. WING		08/11/2016
NAME OF PROVIDER OR SUPPLIER  TARBORO NURSING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886		1 00/11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 278	hypertension. Review of Resident dated 7/30/2015 inc as having Level II P Resident #109's massessment dated had been assessed An interview with thon 8/10/2016 at 9:1 it had been her respinformation on the NPASRR information her by the social womany of the resider had been living in the information had line.  An interview with the conducted on 8/10/stated Level II PASI prior to admission a placed on the reside stated all new admithe morning meetin PASRR information  An interview with the was conducted on 8/10/stated she woe complete and accur would expect the discommunicate with eaccuracy and Level be captured on the	#109's PASRR information dicated he had been assessed PASRR. Dist recent Annual MDS 12/09/2015 did not indicate he I as having Level II PASRR. Dist recent Annual MDS 12/09/2015 did not indicate he I as having Level II PASRR. Dist recent Annual MDS II PASRR DISTARR DISTA	F 278		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345510	B. WING		08/11/2016
	NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLÉTIO
F 278	dated 2/24/2015 inc assessed as having Review of Resident MDS assessment d indicate she had be II PASRR. An interview with the on 8/10/2016 at 9:1 it had been her resp information on the N PASRR information her by the social wo many of the residen had been living in the the information had line. An interview with the conducted on 8/10/2 stated Level II PASF prior to admission a placed on the reside stated all new admis the morning meeting PASRR information An interview with the was conducted on 8 DON stated she wo complete and accur would expect the diff	#119's PASRR information dicated she had been I Level II PASRR. #119's most recent Annual ated 2/09/2016 did not en assessed as having Level  e MDS nurse was conducted 5 AM. The MDS nurse stated consibility to code the PASRR MDS assessments. The would be communicated to corker. The MDS nurse stated at who were Level II PASRR are facility for some time and just dropped off along the  e Social Worker (SW) was 2016 at 9:33 AM. The SW RR was usually evaluated and this information would be cent's medical record. The SW sisions were discussed during gs. The SW indicated Level II was noted on the MDS.  e Director of Nursing (DON) 3/11/2016 at 8:22 AM. The uld expect the MDS to be cate. The DON stated she	F 278		
	communicate with e accuracy and Level be captured on the 11. Resident #142 v	each other to ensure MDS II PASRR information should			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	` ′	(X3) DATE SURVEY COMPLETED	
		345510	B. WING _	<del></del> -		08/11/2016	
	ROVIDER OR SUPPLIER  O NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	·		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 278	cirrhosis.  His admission Minim 7/29/16 indicated he attention fluctuated. having little energy may have wandering behasupervision with tranand in halls and with unit. The fall history had been no falls sin A review of the nurse 12:38 PM revealed a Meeting was held fol on 7/26/16 at 3:00 Al An interview was coron 08/10/2016 at 3:4	um Data Set (MDS) of had poor cognition and his He reported feeling tired or nost days. He was noted to aviors. He required sfers, walking in his room locomotion on and off the of the MDS indicated there ce his admission.	F 2				
	facility and all available She stated she does also attends the fall had Fall Meeting. She storage for the facility. She explor in the early morning 24-hour report which administration the nemeeting. She stated MDS nurse. She stated salso attends at the stated she was a coding error.	ole personnel responded. respond to those pages and huddle or Interdisciplinary ated that a fall occurring on been documented on the sessment. She stated it was adducted 08/10/2016 at 4:38 of Nursing. She stated all huded to any fall occurring in ained if a fall occurs at nighting, it is documented on the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345510	B. WING _			08/11/2016	
	NURSING CENTER	•	,	STREET ADDRESS, CITY, STATE, ZIP C 911 WESTERN BOULEVARD TARBORO, NC 27886	CODE		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 278	Continued From page be coded on the adm		F 2	278			