PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345051	B. WING		C 10/20/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ANSON H	EALTH AND REHABILITA	ATION		405 SOUTH GREENE STREET	
ANOON	LALITI AND KLITADILITA			WADESBORO, NC 28170	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	INITIAL COMMENTS		F 000		
F 247 SS=D		TO NOTICE BEFORE	F 247		11/15/16
		ht to receive notice before r roommate in the facility is			
	by: Based on resident in record review the faci notice of a roommate (Resident #73) review and discharge. The faci notice of a roommate (Resident #73 was add 7/13/16. The admission assessment dated 7/2 moderate cognitive in An interview with Resident 10/17/16 at 11:47 AM had a new roommate no notification provided A record review was of A Social Work (SW) prindicated a roommate #73's room without according to the reported that as the normoved into Resident in became upset and resident in the record review was of the reported that as the normoved into Resident in the record review upset and resident in the record review upset and resident in the record reside	mitted to the facility on ion Minimum Data Set 20/16 indicated he had npairment. sident #73 was conducted on Resident #73 indicated he moved into his room with		Disclaimer Clause: Preparation and or execution of this plat does not constitute admission or agreement by the Provider of the truth the facts alleged or conclusion set forth the statement of deficiencies. The plat prepared and or executed solely becaut it is required by the provisions of the Stand Federal law. F247 1.) Resident #73 transferred to a privation on 10/21/16. The move was discussed with the resident on 10/21/1 by the Social Worker and documented the progress notes. The Responsible Party was also notified of the room change on 10/21/16 by the Social Worker and documented in the progress notes 2.) The Social Worker received an in-service by the Director of Nursing or 10/20/16 to notify residents and Responsible Parties for a planned roor change and notify the resident in the received and in the progress and responsible Parties for a planned roor change and notify the resident in the received and in the progress and responsible Parties for a planned roor change and notify the resident in the received and in the progress and responsible Parties for a planned roor change and notify the resident in the resid	of n on n is use tate 6 in ker
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	1	TITLE	(X6) DATE

11/11/2016 **Electronically Signed**

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

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TO WILL OF T	NOVIDER OR COLL FIER			405 SOUTH GREENE STREET	352		
ANSON H	EALTH AND REHABILIT	ATION		WADESBORO, NC 28170			
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F 247	Continued From page	e 1	F 2	47			
	the move. The note in the Marketing Director Resident #73 the rear Resident #73 continuadditionally reported #73 was then called verified in their voicemail. A grievance form date Resident #73. The general was a reported he had change. The form rear to stay in the room were room was available a agreeable to moving. An interview was condulted and the resident advance of the change was informing the resident advance of the change was initially admitted room that he shared was initially admitted room that he shared spouse. She reported on 8/8/16 and Resides semi-private room all the Marketing Director on 8/10/16 at the time staff had failed to pro Resident #73 of the atto his room. The SW	indicated that the SW and or attempted to explain to sons for the change, but led to be upset. The note a family member of Resident with a detailed explanation l. ed 8/10/16 was filed by rievance indicated Resident not liked the roommate ported Resident #73 refused ith the roommate. A private and Resident #73 was to a private room.	Γ2	that they will be receiving a roommate. Room changes monitored for all residents in from 10/20/16. The Admiss Coordinator received the in-11/8/16 by the Director of N up to the Social Worker in h On weekends, it will be the of the Charge Nurse on the notification of room changes will be done by a member of administrative nursing to be notification took place. Any Worker or Admissions Coor receive the education during 3.) Utilizing a Room Chang Indicator Audit Tool for Resi Director of Nursing will revie notes to assure residents on Responsible Party were not change and the resident in also notified of receiving a results of the monitoring for concerns. 4.) The Administrator will presults of the monitoring to a Quality Assurance Committed for trends and the need for monitoring.	will be moving forward sions -service on ursing as back her absence. responsibility hall for s. Follow-up of sure new Social dinator will g orientation. ge Quality dents, the new progress or the iffied of room the room was new roommate. s weekly x 2 or, then weekly x nonth. The d initial the trends and oresent the the Executive nee monthly x 3		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		C 10/20/2016	
	ROVIDER OR SUPPLIER	ATION		STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170	10.20.20	
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F 247 F 250 SS=D	An interview was con Nursing on 10/19/16 a her expectation was f provided for a roomm 483.15(g)(1) PROVIS RELATED SOCIAL S The facility must prov services to attain or n	ducted with the Director of at 3:50 PM. She indicated or advance notification to be ate and/or room change. ION OF MEDICALLY ERVICE ide medically-related social naintain the highest mental, and psychosocial	F 24		11/15/16	
	by: Based on record revifacility failed to impler interventions (interventions to addresse (Resident #73), demonstrates in depression of treatment, agitation following the death of 1 of 1 residents reviews ocial services. The second services and 7/13/16 with multiple depression. The admassessment dated 7/2 moderate cognitive in Interview for Mental Second interview for Mental Second in the second in the second interview for Mental Second in the second in the second interview for Mental Second in the second in the second in the second interview for Mental Second in the second in the second interview for Mental Second in the second in the second in the second interview for Mental Second in the s	n, crying outbursts, refusals , and combative episodes his wife (Resident #91) for wed for medically related		Disclaimer Clause: Preparation and or execution of this places not constitute admission or agreement by the Provider of the trut the facts alleged or conclusion set for the statement of deficiencies. The place prepared and or executed solely becaute it is required by the provisions of the and Federal law. F250 1.) Resident #73 was interviewed an assessed by the Social Worker on 10/20/16 for signs and/or symptoms of depression with none present. The SWorker documented the assessment the progress notes. Resident #73 was seen and re-evaluated by the Social Worker again on 10/24/16, 10/31/16,	h of rth on an is ause State nd of Social in as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		0/20/2010	
				405 SOUTH GREENE STREET			
ANSON H	EALTH AND REHABILITA	ATION		WADESBORO, NC 28170			
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F 250	Continued From page	e 3	F 2	50			
	included the need for depressive mood whi medication.	monitoring for evidence of le on antidepressant	1 2	11/4/16. The resident will be vis regularly by Clergy, continues to services of physical and occupa therapy without refusal, and will	o receive ational receive		
	mood and antidepres indicated Resident #7	care related to depressive sants was updated and '3's wife passed away		regular visits by the facility psyc services to assure the resident managing any grief. The reside	is ent has		
	There were no interven	ial for depressive mood. entions added to this plan of		been visited weekly by the Socioto identify any signs and/or sym	ptoms of		
	care to address the ir Resident #73's depre			grief and is scheduled to meet he lunch and visit the cemetery. The is invited and assisted to attend	ne resident		
	A review of Resident #73's medical record revealed he was initially admitted to a semi-private room that was shared with his wife,			of choice and the Activity Direct completed a new activity interes assessment on 11/8/16 to identity	st		
	T	lent #91 passed away on		new interests. The resident has no prn doses of Ativan since 10 2.) A 100% audit was complete	received /19/16.		
	a BIMS was conducted Resident #73 had different	note dated 8/11/16 indicated ed yesterday (8/10/16) and ficulty with the interview dicated he had significant		Social Worker on 10/21/16 to id residents with the potential to be by grief over the loss of an imm family member in the past 6 mo	e affected ediate		
	in mental status as R	This revealed a decrease esident #73's previous BIMS 6 MDS was an 11, which		residents were identified. The S Worker received an in-service b Director of Nursing on 10/20/16	y the		
	cognition. The SW n	a moderate impairment in ote also indicated Resident down due to the recent		address the grieving process fo resident with the loss of an imm family member. A letter was se	ediate		
	talked about him and	e SW documented, "We his wife for a bit. He stated mendously." The SW		Responsible Parties on 11/11/16 request notification to the facility Administration Staff for any imm	y		
	reported she would c	ontinue to monitor for signs pression and grief and would		family member losses to assure facility will assist with the grieving for the resident. The request with the grieving facility will assist with the grieving facility will be assisted to the family member losses to assure family will be assisted to the family member losses to assure family will be assisted to the family member losses to assure family member losses to assure family will be assisted to the family member losses to assure family will be assisted to the family will be assisted to	the ng process ill also be		
	Physical Therapy (PT notes for August 2010	pational Therapy (OT), -), and Speech Therapy (ST)		presented on each new admissing facility. Any new Social Worker receive the in-service during orion. The facility has a contract with Care for mental health services.	rs will entation. On-Site		

NAME OF PROVIDER OR SUPPLIER ANSON HEALTH AND REHABILITATION MAIL D (SAMMARY STATEMENT OF DEPICIENCIES) TAG F 250 Continued From page 4 crying outbursts, episodes agitation, and an increase in confusion. A review of the nursing notes for August 2016 revealed Resident #73 was tearful at times on 8/9/16, 8/10/16,	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345051		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345051	B. WING		C 10/20/2016	
	NAME OF PROVIDER OR SUPPLIER ANSON HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170	10/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 250		=	F 25	0		
	A SW note dated 9/reviewed Resident stated, "he did no wants to stop all the statement was mad Resident #73 was rfor his suicidal idea indicated the SW coinstructed the nursi on Resident #73. Tinterview she had w During the interview still being upset about indicated Resisymptoms of depreshe was going to coand make appropria					
	September 2016 re continued to have re noted lethargy, cryinagitation, and an incomplete determined and the continued Resident and increased agitation Resident #73 was in of increased agitation removing his clothing 19/4/16 Resident #73 confusion and physioehaviors toward still	vealed Resident #73 nultiple refusals of treatment, ng outbursts, episodes of crease in confusion. d 9/3/16 through 9/5/16 #73 had episodes of and confusion. On 9/3/16 ndicated to have had episodes on in intervals, he was ng, and was yelling at staff. On 3 was indicated to have had ically and verbally abusive taff. The nurse indicated ere made to reorient and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345051	B. WING			C 10/20/2016
NAME OF PROVIDER OR SUPPLIER ANSON HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP 405 SOUTH GREENE STREET WADESBORO, NC 28170	•	10/20/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 250	redirect Resident #73 Resident #73 was ind agitation and confusion A physician note date #73 had recently lost depression he had be Ativan. The physician Resident #73's grief in current medications a symptomatic support. OT and ST notes date indicated the therapis regarding Resident # OT note dated 9/7/16 Therapist discussed of and the SW regarding behaviors and his dec participation. The RN Occupational Therapi an antidepressant and shared with the physi 9/8/16 indicated the S nursing staff regarding condition, which inclu decline. The nurse of Speech Therapist that condition. A SW note dated 9/9/ had been very sad an Resident #73 was not wife's death. Resider had little pleasure in of down, and was feeling	without success. On 9/5/16 licated to have continued on. d 9/6/16 indicated Resident his wife and because of his een started on Zoloft and indicated his plan to treat eaction was to continue his is well as the provision of ed 9/7/16 and 9/8/16 ts had spoken with staff 73's change in condition. An indicated the Occupational concerns with nursing staff g Resident #73's depressive creased therapy I had informed the st that Resident #73 was on d his report was going to be cian. An ST noted dated speech Therapist spoke with g Resident #73's current ded lethargy and a notable in duty had reported to the t she was aware of his 16 indicated Resident #73 and has had behaviors. It is indicated to continue to grieve his int #73 reported to SW he doing things, was feeling g tired. The SW indicated ned he missed his wife and	F2	250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 250	with Resident #73 ar having a good day. #73 became tearful a missing his wife and passed away. The Resident #73 for "ab #73 was indicated to end of the conversat A SW note dated 9/1 reported feeling dow indicated, "[Resident missing his wife and reported she spoke with missing his wife and reported he was feel had little interest in deeling tired. The SV #73's] mood fluctuate are attributed to missing additionally indicated to love to talk about lassessment. A review of the nursi indicated Resident # on 9/7/16, 9/17/16, 9/28/16, and 9/29/16 A SW note dated 10/1 reported he had little things, he was feelin bad about himself. The symmetric symmetri	2/16 indicated she spoke and he reported he wasn't The note indicated Resident and he had reported he was was very sad that she SW reported she spoke with out 10 minutes." Resident have been smiling at the ion with the SW. 5/16 indicated Resident #73 in or depressed. The note #73] once again stated having a bad day." The SW with Resident #73 "for a few ife and he was then in a 3/16 indicated Resident #73 ing down or depressed, he oing things, and he was V indicated, "[Resident es but mainly, his bad days sing his wife." The note I that Resident #73 appeared his wife during each SW and notes for September 2016 and the was combative at times and the was feeling interest or pleasure in doing g down, and he was feeling interest or pleasure in doing g down, and he was feeling interest or missing his wife.	F 2	50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	ATE SURVEY DMPLETED	
		345051	B. WING _			C 10/20/2016	
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F 250	Continued From page	ge 8	F 2	50			
	10/7/16, 10/10/16, 1 10/16/16 indicated If at times. An interview was considered If at times. An interview was c	sing notes dated 10/5/16, 10/11/16, 10/15/16, and Resident #73 was combative onducted with the SW on M. She indicated she was nt #73. The plan of care for d to the increased potential d due to the death of his wife he SW. The interventions ted following the death of were reviewed with the SW. esident #73 had been care nitoring of his depressive ted the monitoring revealed for Resident #73. She #73's behavioral changes codes, increased depression, and refusals of therapy. The ent #73's antidepressant usted by the physician and he antianxiety medication as the the noted behavioral e SW was asked what all interventions were lifess Resident #73's following the death of his wife ditional non-pharmacological					
	The SW interview of had met with Reside as required by her since She reported the SN BIMS and the mood during her interview						

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F 250	about his wife and him talk about his was able to note for Resident #3 she would provide right signs and symptom note that indicated and make appropriation were addressed with she had not provide Resident #73 nor had additional services and changes that occur wife. An interview was considered with Reside #73 was upset after indicated Resident froom on some days his room. Nurse #1 spells and she had him talk about his with days she was able to was receptive and so days he had not was indicated she though involved to assist Right process, but she was the social service in An interview was considered she worker revealed Resident # depression when had multiple occasions.	is mood appeared to improve to talk about her. The SW and added 8/11/16 that indicated esources as appropriate for so of grief as well the 9/1/16 she would monitor for changes ate referrals as necessary the the SW. The SW revealed additional resources to additional resources to address the behavioral red following the death of his anducted with Nurse #1 on M. Nurse #1 reported she and isolated himself in his about the death of his wife. She if ya had isolated himself in his about the death of his by refusing to come out of stated he also had crying tried to console him by letting rife. She reported there were no talk to Resident #73 and he similed, and there were other inted to do anything. Nurse #1 the social services had gotten esident #73 with the grieving asn't sure about any details of	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER EALTH AND REHABILIT			STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170	•	0/20/2016	
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F 250	needed to participated days when the educated the educated that also become agrithere were other day. An interview was corning (DON) on 10 DON stated she was and she had also become agrithere were the facility of the education as needed process. She stated non-pharmacological place for Resident #7 reaction. The DON is into it for more information in the educated that when Resident that after passed away he see indicated there were the facility he had should be indicated there were the facility he had should be indicated there were the facility he had should be indicated there were the facility he had should be indicated there were the facility he had should be indicated there were the facility he had should be indicated there were the facility he had should be indicated there were the facility had refused to gonly minimally in OT he had participated had random periods he had tried to distrain	about his wife. She vided Resident #73 mportance of PT and why he at PT #1 indicated there were ation worked and Resident eeable to PT treatment, and is he continued to refuse. Inducted with the Director of 1/19/16 at 3:50 PM. The familiar with Resident #73 en familiar with his wife, indicated after the death of the was started on a new left as an antianxiety do to assist with the grieving I she was unsure what other interventions were put into 1/3 to address his grief indicated she was going look	F 29	50			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345051	B. WING		C 10/20/2016
	NAME OF PROVIDER OR SUPPLIER ANSON HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170	10/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 253 SS=B	concentration and confected as well. He sable to answer question he had been able to condicated he had thous Resident #73 were sine had discussed his and the SW regarding behaviors and his departicipation. OT #1 him Resident #73 was A follow up interview DON on 10/20/16 at 9 indicated the intervent included adjusting his she was unaware of a interventions that were Resident #73's grief resident #73's grie	ally indicated Resident #73's gnition seemed to be stated Resident #73 was not ons or follow directions as to previously. OT #1 ght the changes with gns of grief. He revealed concerns with nursing staff g Resident #73's depressive creased therapy indicated staff had informed so on an antidepressant. Was conducted with the 2:00 AM. The DON tions for Resident #73 medications. She revealed any non-pharmacological in implemented to address eaction. KEEPING & EVICES Ide housekeeping and a comfortable interior. This is not met as evidenced in and staff interview, the pain clean wheelchairs on a findings included: 57AM, an observation of chair revealed the and debris on the frame,	F 2:		uth of orth on olan is cause

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE		10/20/2010
				405 SOUTH GREENE STREET		
ANSON H	EALTH AND REHABILITA	ATION		WADESBORO, NC 28170		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETION DATE
F 253	Continued From page	<u>.</u> 12	F 25	53		
00	Continued From page	, 12	1 2	and Federal law.		
	On 10/17/16 at 4:17P	M an observation of		and rederal law.		
		elchair revealed the frame of		F253		
		usty and dirt was noted on		1.) Wheelchairs for Residents	#14 and	
	the frame of the whee	_		#67 were power washed by		
				Housekeeping on 10/21/16; Res	sident#	
	On 10/17/16 at 2:59P	M, an observation of		10 □s motorized wheelchair was		
	Resident #10 's elect	tric wheelchair revealed the		by Housekeeping on 10/21/16;		
	frame of the wheelch	air was dirty with food		wheelchairs for Room 2A, 4B, 7	'B, 20B,	
	particles and was dus	sty.		25A, 25B, 26, 28, 37, 41, 42, 44		
				55 were power washed by Hous		
	On 10/18/16 at 3:00P			along with all remaining wheeld		
		tric wheelchair revealed the		facility by 10/25/16. All remaining	•	
		air remained dirty with food		motorized wheel chairs were als		
	particles and was dus	sty.		by Housekeeping staff by 10/25		
	On 10/10/16 at 9:45A	M on observation of the		2.) The second shift and night		
		.M, an observation of the ducted and revealed the		nursing staff received an in-serving housekeeping on cleaning whee		
	following:	ducted and revealed the		The in-service was completed of		
		r frame dusty and dirt noted		11/10/2016. The second and thi		
	on frame.	manne adety and antineted		nursing staff will clean standard		
		r had dust and dirt on frame.		wheelchairs and Broda chairs w		
		r had dirt and food particles		ongoing. Housekeeping will cle	•	
	noted on the wheels/	frame of the chair.		Geri-chairs and motorized whee		
	Room 14B (Resident	#10)electric wheelchair		weekly ongoing. Housekeeping	will power و	
		he frame on the chair.		wash all chairs as needed.		
		dirt noted on the wheels and		3.) Utilizing a Wheelchair and		
	frame of the wheelch			Chair Cleaning Schedule Audit		
	,	#14)dust and dirt noted on		Unit Managers review each mon	-	
	the frame of the whee			Monday through Friday to assur		
	frame of the wheelch	#67)dust noted on the		chairs and Broda chairs have be cleaned as scheduled and verifi		
		ust noted on the frame of the		cleanliness of 3 random chairs.	у	
	wheelchair.	ast noted on the hame of the		Housekeeping will utilized a Ge	ri-Chair	
		irt noted on the frame of the		and Motorized wheel chair Audi		
	wheelchair.	and the second s		weekly cleaning of those chairs		
		irt noted on the frame of the		Managers will review the Geri-C		
		ght brake on the wheelchair		Motorized wheel chair audits on		
	did not lock.	-		to assure those chairs have bee	-	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WING_				C 20/2016
	ROVIDER OR SUPPLIER			40	TREET ADDRESS, CITY, STATE, ZIP CODE D5 SOUTH GREENE STREET VADESBORO, NC 28170	<u> 10/</u>	20/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278 SS=D	Room 41dust and d wheelchair. Room 42dust and d wheelchair. Room 44Bdust and din wheelchair. Room 47 dust and din wheelchair. Room 55dust and din wheelchair. On 10/19/16 at 10:30 conducted with the D Director of Nursing of wheelchairs. Many of and dusty wheelchair were not disturbed duthere was a cleaning wheelchairs. The chase shower room by the restriction of the schedule and as a had visible food/ dirt of 483.20(g) - (j) ASSES ACCURACY/COORD. The assessment must resident's status. A registered nurse mit each assessment wit participation of health	irt noted on the frame of the irt noted on the frame of the dirt noted on the frame of the residence of the irt noted on the frame of the AM, an interview was irector of Nursing. The oserved several of the frame of the frame of the oserved several of the frame of the irt noted on the frame of the oserved several of the frame of the irector of Nursing. The oserved several of the severe in an activity and uring the activity. She stated schedule for washing the airs were washed in the night shift Monday through irs should be washed every of Nursing stated she clean the wheelchairs per needed if the wheelchairs on them. SSMENT DINATION/CERTIFIED of accurately reflect the ust conduct or coordinate in the appropriate in professionals.		253	and verify cleanliness of 2 random chain weekly. Monitoring will occur Monday through Friday x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weethen monthly x 1. The Administrator will review and initial the audit tools weekly weeks, then monthly x 1 for trends and concerns. 4.) The Administrator will present the results of the monitoring to the Executive Quality Assurance Committee monthly for trends and the need for continued monitoring.	eks, ill v x 8	11/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		C 10/20/2016	
	ROVIDER OR SUPPLIER	TATION	STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170		10/20/2016	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 278	assessment must sign that portion of the assument must sign that portion of the assument must support to a civil more statement in a subject to a civil more subject to a civi	completes a portion of the gn and certify the accuracy of esessment. Medicaid, an individual who ly certifies a material and resident assessment is ney penalty of not more than essment; or an individual who ly causes another individual and false statement in a t is subject to a civil money than \$5,000 for each	F 278			
	by: Based on record refacility failed to code (MDS) assessment (Resident #92) of 1 shospice care. Findin Resident #92 was as 5/15/15 with multiple Congestive Heart Faassessment dated 8 Resident #92's cogn receiving hospice caassessment further it that Resident #92 had disease that may regless than 6 months.	view and staff interview, the the Minimum Data Set accurately on prognosis for 1 sampled resident receiving a included: dmitted to the facility on a diagnoses including ailure. The quarterly MDS //29/16 indicated that ition was intact and she was re while at the facility. The indicated under the prognosis and no condition or chronic sult in a life expectancy of		Disclaimer Clause: Preparation and or execution of this does not constitute admission or agreement by the Provider of the truthe facts alleged or conclusion set fithe statement of deficiencies. The prepared and or executed solely be it is required by the provisions of the and Federal law. F278 1.) The Minimum Data Set of 8/29. Resident #92 was modified by the Nurse on 10/19/16 to reflect the chathe prognosis question to yes. The modification was transmitted to the Agency on 10/19/16. 2.) The Director of Nursing provide in-service to the MDS Nurse on 10/19/16.	uth of orth on olan is cause e State /16 for //DS ange of State	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WING _			l	C / 20/2016
	ROVIDER OR SUPPLIER			40	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTH GREENE STREET /ADESBORO, NC 28170	10/	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280 SS=D	indicated that Resided hospice care since 2/ On 10/19/16 at 1:55 Finterviewed. She staft that if the resident was the prognosis should life expectancy of less On 10/19/16 at 3:55 F (DON) was interviewed she expected the MD	ont #92 was receiving 23/16. PM, the MDS Nurse was used that she did not know is receiving hospice care, be checked "yes" under is than 6 months. PM, the Director of Nursing and. The DON stated that is to be accurate.		278	from the R.A. I. Resident Assessment Instrument Version 3.0 Manuel Section J1400 for prognosis coding. A 100% a for all residents receiving Hospice services was completed by the Director Nursing on 10/19/16 to identify any residents that may have been affected the same coding. One other resident widentified and the MDS was made awarfor correction. The MDS Nurse correct the MDS assessment and the modification was transmitted to the Sta Agency on 10/19/16. Any newly hired MDS nurses will receive the education during orientation. 3.) Utilizing a MDS Hospice/Prognosis Quality Indicator Audit Tool, the ADON review all physicians orders for new orders for Hospice services to assure the resident MDS was properly coded correctly for the prognosis question. Monitoring will occur weekly x 4 weeks then twice monthly x 1 month, then monthly x 1. The Director of Nursing wereview the Quality indicator Audit Tool weekly x 4 weeks, then twice monthly x month, then monthly x 1 for trends and concerns. 4.) The Director of Nursing will present results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring.	udit r of by vas re ed te s will he	11/15/16
	The resident has the incompetent or other	right, unless adjudged vise found to be					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION		PLETED
		345051	B. WING _				C 20/2016
	ROVIDER OR SUPPLIER	ATION		40	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTH GREENE STREET VADESBORO, NC 28170		20/2010
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	participate in plannin changes in care and A comprehensive car within 7 days after the comprehensive assess interdisciplinary team physician, a register for the resident, and disciplines as determand, to the extent prathe resident, the resident ilegal representative;	the laws of the State, to g care and treatment or treatment. The plan must be developed	F2	280			
	by: Based on medical reinterview, the facility to reflect the diet ord August physician's residents reviewed for The findings included Resident #34 was ac Cumulative diagnose. An Annual Minimum 10/7/16 indicated Reand long term memo severely impaired in Resident #34 require eating. Her weight was reflected to the facility of the fa	T is not met as evidenced ecord review and staff failed to revise the care plan er of pureed diet as noted on orders for one of three or nutrition (Resident #34). d: d: di: dmitted to the facility 6/23/05. es included dysphagia. Data Set (MDS) dated sident #34 had short term ry impairment and was decision-making skills. ed extensive assistance with vas noted at 94 pounds with n noted. She was on a			Disclaimer Clause: Preparation and or execution of this plate does not constitute admission or agreement by the Provider of the truth the facts alleged or conclusion set forth the statement of deficiencies. The plant prepared and or executed solely becaute it is required by the provisions of the Stand Federal law. F280 1.) The care plan for Resident #34 was updated to include the resident □s curred diet order by the MDS Coordinator on 10/19/16. 2.) The Director of Nursing in-serviced	of n on n is ise tate	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPL	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		10/2	: :0/2016	
	ROVIDER OR SUPPLIER	ATION		STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 280	mechanically altered On 10/19/2016 at 8:2 observed eating breatoursing staff. Reside of a pureed diet. Physician orders for a staff and a diet order A physician 's order order change to mechanical soft diet with thin lique. Speech therapy note Resident #34 was se 6/20/16 through 7/9/2 discharged from specific soft diet with thin lique. Physician orders for a were reviewed and refor pureed diet. A review of Resident 12/13/16 and reviewed Resident #34 had a pure dehydration due to a dementia and poor for Approaches added of mechanical soft diet in plan did not indicate diet. On 10/20/2016 at 8:3 conducted with the Diff speech therapy wo therapy would send a side of the speech therapy wo therapy would send a side of the speech therapy wo therapy would send a side of the speech therapy wo therapy would send a side of the speech therapy wo therapy would send a side of the speech therapy wo therapy would send a side of the speech therapy wo therapy would send a side of the speech therapy wo therapy would send a side of the speech therapy wo therapy would send a side of the speech therapy wo therapy would send a side of the speech therapy would send a side of the speech therapy wo therapy would send a side of the speech therapy wo therapy would send a side of the speech therapy wo the speech the speech therapy wo the speech the speech therapy wo the speech the speech the speech therapy wo the speech the speec	diet. 21AM, Resident #34 was okfast. She was being fed by ent #34 had double portions July 2016 indicated Resident for pureed foods. dated 7/7/16 revealed a diet chanical soft diet with thin s reviewed and noted en by speech therapy from 16. Resident #34 was ech therapy on a mechanical ids. August and September 2016 evealed a physician 's order #34 's care plan dated ed on 10/7/16 revealed potential for weight loss and history of weight loss, and and fluid intake.	F 28	the MDS Nurse on 10/20/16 to in aspects of residents dietary ne residents care plans. A 100% resident diet orders was complet 10/24/16 by the Director of Nursi compare with the care plan to as accuracy. The audit revealed the physician orders matched the care-planned diets. Any newly hourses will receive the education orientation. 3.) Utilizing a Diet Order Care Foundity Indicator Audit Tool, the ADirector of Nursing will review all orders for diet changes to assure resident scare plan was update Monitoring will occur Monday the Friday x 2 weeks, then twice weeks, then weekly x 4 weeks, then weekly x 4 weeks, then weekly x 1 month. The Director Nursing will review and initial the Indicator Audit Tool weekly x 8 weeken monthly x 1 month for trend concerns. 4.) The Director of Nursing will the results of the monitoring to the Executive Quality Assurance Commonthly x 3 for trends and the necontinued monitoring.	eds in the audit of red on ing to sure at all sired MDS a during Plan Assistant I new et the ed. ough ekly x 2 hen of e Quality reeks, is or present ne mmittee		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170	10/20/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 280	Dietary Manager state Resident #34 received July. She said nursing after the diet was changed the diet consistency by not remember exactly occurred and stated sher nutrition notes and care plan to reflect the Conducted with the Michanged the care plan order for mechanical she stated she changed are plan because shorder for the diet charshe had not received.	ed she remembered that d a mechanical soft diet in g staff notified her sometime nged and informed her ding the food in her mouth out. Nursing staff changed ack to pureed. She could when the diet change the should have written it in d should have changed the	F 28		
F 282 SS=D	conducted with the Distated Resident #34 v mechanical soft diet a and pocketing food in downgraded her diet was tolerating that diecare plan should have currently being receiv 483.20(k)(3)(ii) SERV PERSONS/PER CAR	ICES BY QUALIFIED E PLAN If or arranged by the facility	F 28.	2	11/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345051	B. WING		4	C 0/ 20/2016	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	•	0/20/2016	
NAME OF T	NOVIDEN ON OOF FEIEN			405 SOUTH GREENE STREET	_		
ANSON H	EALTH AND REHABI	LITATION					
				WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	Continued From p	age 19	F 28	2			
	by:	ENT is not met as evidenced					
		review and staff interview, the		Disclaimer Clause:			
		low the plan of care for		Preparation and or execution	•		
	evaluation by a mental health provider as needed			does not constitute admission			
		ddress the assaultive behavior		agreement by the Provider of			
		(Resident #8) reviewed for		the facts alleged or conclusion			
		eening and Resident Review		the statement of deficiencies.	•		
	(PASRR) Level II.	The findings included:		prepared and or executed sol			
	Desident #0 wee i	nitially admitted to the facility on		it is required by the provisions and Federal law.	or the State		
		nitially admitted to the facility on ole diagnosis that included		and rederal law.			
		xiety, and depression.		F282			
	Scriizoprii Criia, ari.	kicty, and depression.		1 202			
	A review of Reside	ent #8's medical record		1.) The Guardian for Reside	nt #8 agreed		
		current PASRR level II		on 10/25/16 for the resident to	_		
		2/22/16) related to a serious		the facility outside psychiatric	•		
	mental illness.	,		The scheduling of the appoint			
				discussed with Resident #8 by			
	The quarterly Mini	mum Data Set (MDS)		Worker on 10/25/16. An appo			
	assessment dated	4/13/16 indicated Resident #8		a walk-in was scheduled for the	ne resident		
	had moderately in	npaired cognition. He was		with the psych services for 10	/26/16. The		
		ad verbal behaviors 1 to 3 days		resident was sent by the outsi			
	during the 7 day re	eview period. Resident #8 had		on 10/26/16. The resident rep	oorted he		
		d antipsychotic medication,		would follow medication evalu			
		ation, and antidepressant		through the nursing home. T	•		
		f 7 days during the MDS review		Pharmacist will review the res			
	period.			medications on the November			
		B : 1 + 1/10 : 1 + 1 + 1		report recommendations to th	•		
		or Resident #8, included the		The resident will be seen by a	•		
		nonitoring for behaviors		contracted in-house psych se	rvice before		
		chizophrenia and anxiety. This		the end of November.	atad an		
	'	ted on 8/4/15 and most recently		2.) A 100% audit was completed by the Social Worker			
		6, indicated Resident #8 was a he interventions included		11/8/16 by the Social Worker			
		ne interventions included al health provider as needed for		of Nursing to identify any residual psychiatric diagnosis and neg			
	the evaluation of b	•		behaviors to include hitting an			
	i iiio ovalualion Ol L	onaviora.	1	Deliaviors to include mitting an	ia Nickiilia,	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WING				20/2046	
NAME OF DE	ROVIDER OR SUPPLIER	040001		-	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	20/2016	
NAME OF F	NOVIDER OR SUFFLIER							
ANSON H	EALTH AND REHABILIT	TATION			05 SOUTH GREENE STREET			
				٧	VADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 282	Continued From pag	e 20	F2	282	hallucinations and/or delusions,			
	A nursing note dated	6/15/16 indicated when			combative behavior, and paranoia. The	Э		
	-	activities he went up to the			audit revealed residents with the poter			
		es were over. The note			for behaviors based on diagnoses and			
	•	the volunteer went to see			referral orders were obtained for those			
	what was wrong and	Resident #8 punched him in			residents. Those residents identified			
	the stomach. Reside	ent #8 reportedly stated, "well			were presented to the Medical Director	r for		
	he should not have o	come over there."			orders for psychiatric services by the			
					Social Worker on 11/8/16. Those			
		(NP) note dated 6/15/16			residents were referred to the in-house	;		
		omplaint/nature of presenting			psychiatric services provider on 11/8/1	6 by		
	problem for the visit with Resident #8 was "hit				the Social Worker for evaluation. The			
		indicated Resident #8 had a			Charge Nurse or the Unit Manager on			
		nia with hallucinations and			duty will be responsible for MD notifica	tion		
	episodes of being co				of any needed referrals based on			
		as admitted to the hospital			behaviors. The Director of Nursing in-serviced the Social Worker on 10/20	V/4.6		
	_	combative behavior and report that [Resident #8]			to assure resident with new orders for	<i>)</i> / 10		
		ne abdomen because he			psychiatric services are seen within on	۵		
		to the preacher after			week or sooner as possible.	C		
		plan indicated a referral for a			3.) Utilizing a Behavior Quality Indica	ator		
		ion for assaultive behavior.			Audit Tool, the Unit Managers will read			
					nursing progress notes daily and the			
	A physician's order d	lated 6/15/16 indicated a			Director of Nursing will review progress	3		
		or assaultive behavior for			notes on the weekend x 14 days to			
	Resident #8.				identify any behaviors to include hitting	I		
					and kicking, hallucinations and/or			
	_	7/9/16 indicated Resident #8			delusions, combative behavior, and			
		iggressive and attempted to			paranoia to include Resident #8. The			
		but had instead hit nurse on			physician will be notified of the need for			
	the arm.				psychiatric referral for any newly identi			
		174040: 1: : :			behaviors and repeated behaviors will	be		
	The annual MDS dat				referred to the in-house psychiatric			
		derate cognitive impairment.			services. Monitoring will then occur	_		
		ving had physical behaviors			Monday through Friday x 2 weeks, the			
		ne 7 day MDS review period.			weekly x 4 weeks, then monthly x 1. T	ne		
		indicated to put others at			Administrator will review the audit tool			
		ysical injury. Resident #8			weekly x 8, then monthly x 1 for trends	1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345051	B. WING			C	
		345051	D. WING _			0/20/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
ANSON H	EALTH AND REHABIL	ITATION		405 SOUTH GREENE STREET			
7				WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 282	Continued From pa	ge 21	F 2	282			
	antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period. The Care Area Assessment (CAA) of Resident			 The Administrator will presults of the monitoring to the Quality Assurance Committee for trends and the need for committee monitoring. 	he Executive ee monthly x 3		
	#8's 7/12/16 MDS included, in part, the triggered areas of mood state, behavioral symptoms, and psychotropic drug use. The mood state CAA indicated Resident #8 was receiving mental health (MH) therapy as needed at a community						
based MH provider. The behavioral symptoms CAA indicated Resident #8 had an episode of hitting staff on 7/9/16 that placed others at risk for							
	schizophrenia, anxi potential for fluctua	was noted with diagnoses of ety, and depression and the tions in behaviors and mood. rug use CAA for Resident #8					
	indicated the uses of medication), Seroq	of Klonopin (antianxiety uel (antipsychotic medication),					
	(antidepressant me noted to have comb	ic medication), and Cymbalta dication). Resident #8 was pative behaviors during the					
	noted to have episo	ssment period and he was also odes of delusional behaviors ed during the assessment					
	indicated Resident	otropic drug use CAA also #8 was to be referred to seeded for the management of					
	behaviors and the r of current medication	monitoring of appropriateness ons.					
	informed by Speech #8 was yelling at ar to leave the therapy	nd 8/20/16 indicated she was in Therapy (ST) that Resident nother staff member, refusing y department, was mocking g himself in the chest.					
		AR) note dated 8/25/16 #8 continued to receive					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION IILDING		(X3) DATE SURVEY COMPLETED	
		345051	B. WING_			C 0/20/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 405 SOUTH GREENE STREET WADESBORO, NC 28170		0/20/2016	
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 282	of schizophrenia. Toontinued to have soften accused staff A nursing note date #8 had auditory and delusions. An NP note dated 9 was seen due to a rhe saw and heard hwas reported by sta Resident #8 was indicated for Resident #8 had medications as directional indicated for Resident #8 had medicated for Resident #8 had medication, antianx antidepressant medication, antianx antidepressant medication, and had auditory hall verbal behaviors directional indicated #8 had auditory hall verbal behaviors directional indicated #8 had hitting and kan auditation. There was no docur consultation as order 6/15/16 for Resident	ations related to a diagnosis he note reported Resident #8 ome paranoid behaviors and of taking various items. d 9/25/16 indicated Resident I visual hallucinations and /26/16 indicated Resident #8 hursing report that he stated is parents and his dog. This ff two nights in a row. dicated to be taking his cted. No changes were ent #8. dated 10/5/16 indicated bederate cognitive impairment. aving had behavioral ted toward others on 1 to 3 ay MDS review period. en administered antipsychotic iety medication, and iication on 7 of 7 days during riod. d 10/10/16 indicated Resident ucinations, agitation, and	F 2	282			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345051	B. WING			C	
	ROVIDER OR SUPPLIER EALTH AND REHABILI			STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170	ı	10/20/2016	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 282	Resident #8 had no provider since 1/20/ An interview was concident of the provider on 10/18/16 she was previously stated Resident #8 services in the past used to have a MH facility to see reside provider ceased the several months ago to look into the reconcident of the MH provider stotheir facility. A follow up interview Marketing Director of indicated the MH provider stotheir facility disconting facility as of 2/29/16 2/29/16 the facility's community MH provider stotheir facility as of exident #8 date consultation for assign reviewed with the Minedical record that psychiatric consultation for concreterials at the time She reported she recorder dated 6/15/16 for Resident #8.	t been evaluated by a MH	F 2	82			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345051	B. WING _			C 10/20/2016		
	NAME OF PROVIDER OR SUPPLIER ANSON HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170		10/20/2016		
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 282	consultation. The Mashe was unable to p An interview was co 10/19/16 at 8:33 AM working at the facility she shadowed the p Marketing Director was the facility. The phy dated 6/15/16 for a passaultive behaviors indicated that althout work at the facility at was aware of the reference of the re	Marketing Director indicated rovide additional information. Inducted with the SW on Inducted she began Inducted Inducted She reported	F 2	82				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WING	B. WING		C 10/20/2016	
	ROVIDER OR SUPPLIER	ATION		STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170			20.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION DATE
F 329 SS=D	reported her expectation be followed. The phy for a psychiatric consumpression of the phy for a psychiatric consumpression of the care plan that income the care plan that inc	/20/16 at 9:00 AM. She ion was for the care plan to riscian's order dated 6/15/16 ultation for Resident #8's was reviewed with the DON. dicated Resident #8 was to provider as needed for the ris was reviewed with the she thought the psychiatric er obtained because there cidents of Resident #8 lise. SIMEN IS FREE FROM UGS regimen must be free from An unnecessary drug is any interestive dose (including for excessive duration; or initoring; or without adequate is or in the presence of the which indicate the dose discontinued; or any the easons above. Pensive assessment of a must ensure that residents intipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic I dose reductions, and		329			11/15/16

PRINTED: 11/22/2016 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	
		345051	B. WING		C 10/20/2016	
NAME OF PI	ROVIDER OR SUPPLIER	0.000.		STREET ADDRESS, CITY, STATE, ZIP CODE	10/20/2016	
	(0.115_1, 0.1, 00, 1.2.2.)			405 SOUTH GREENE STREET		
ANSON H	EALTH AND REHABILIT	ATION		WADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 329	Continued From page	e 26	F 32	9		
	by:	Γ is not met as evidenced ecord review, resident, staff,		Disclaimer Clause:		
		nd physician interview, the		Preparation and or execution of thi	s plan	
	-	a clinical indication for the		does not constitute admission or	o pian	
		antipsychotic medication for		agreement by the Provider of the t	ruth of	
	1 of 5 residents (Res	ident #98) reviewed for		the facts alleged or conclusion set	forth on	
	unnecessary medica	tions. The findings included:		the statement of deficiencies. The	·	
				prepared and or executed solely b		
		tially admitted to the facility		it is required by the provisions of the	ne State	
		itted on 9/28/16 with multiple		and Federal law.		
	_	led cervical spinal injury and				
	paraplegia (leg paral	ysis).		F329		
	The annual action of the Adian Control	D-1- O-1 (MDO)		1.) The resident #98 received a d	_	
	The quarterly Minimu	, ,		for use of Seroquel and the care p		
		0/10/16 indicated Resident		updated on 10/19/2016 by the MD Nurse. The resident #98 was exan		
		ent in cognition. He was nad no psychosis and no		and assessed by the attending Ph		
		y MDS review period.		on 10/25/16 and new orders were	ysician	
		dicated to have received		received to discontinue the use of		
		tion on 7 of 7 days during		Seroquel. The order was carried of	out and	
		od. There was no active		the care plan was updated by the I		
		he MDS that justified the use		Nurse on 10/25/16.		
	of an antipsychotic m			2.) A 100% audit of all residents r	eceiving	
				psychoactive medications was con	npleted	
		ated 9/27/16 indicated		on 11/8/16 by Nursing Administra		
		tic medication) 50 milligrams		staff to assure an acceptable diagr	nosis	
	, , ,	night for Resident #98.		was documented for use of the		
	There was no diagno			medication. The audit revealed the		
	Seroquel on the phys	sician's order.		medications had orders with diagn	oses.	
	The plan of sere dete	od 0/27/46 for Docident #00		Clarification orders for appropriate	dod	
		ed 9/27/16 for Resident #98		diagnoses were completed as nee		
	There was no diagno	an antipsychotic medication.		All residents without an acceptable diagnosis were reviewed by the Mo		
	_	tion on the plan of care.		Director for appropriate diagnosis.		
	anapsycholic medica	aon on the plan of care.		orders were written to clarify the us		

Facility ID: 952941

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		C	
NAME OF D	ROVIDER OR SUPPLIER	0-10001	1	STREET ADDRESS, CITY, STATE, ZIP CODE	10/20/2016	
NAME OF PI	ROVIDER OR SUPPLIER					
ANSON H	EALTH AND REHABILITA	ATION		405 SOUTH GREENE STREET		
			WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 329	Continued From page	e 27	F 32	9		
	9/28/16 indicated Ser Resident #98. The no documentation of a cl administration of Serce The Medication Admin from Resident #98's r through 10/18/16 reve Seroquel 50mg each diagnosis indicated for 98's MAR. An interview was con on 10/19/16 at 4:26 P 10/10/16 for Resident MDS Nurse. She sta Medications section of Resident #98 as well section. She indicate no active diagnosis of 10/10/16 MDS that re	inical indication for the oquel. nistration Record (MAR) eadmission on 9/28/16 ealed he had received night. There was no or the Seroquel on Resident ducted with the MDS Nurse M. The MDS dated #98 was reviewed with the ted she coded the of the 10/10/16 MDS for as the Active Diagnosis d she was aware there was oded on Resident #98's lated to the antipsychotic		the medication on or before 11/10/16 Nursing Administration. A 100% licer staff in-service was initiated on 11/9/2 by ADON to assure all medications to include antipsychotic medications has appropriate diagnosis and completed 11/11/16. The in-service included all full-time, part-time and prn (as needed nurses. Any new orders written on the weekends will be addressed by the Charge Nurse on duty with follow-up the DON/ADON as needed. The Unit managers will also check to be sure a orders including psychotropic medical have an appropriate diagnosis on the Medication Administration Record. All newly hired licensed staff will receive education during orientation. 3.) Utilizing a Diagnosis Quality India Audit Tool, the Unit Managers will revall new physicians orders for medical Monday through Friday and the Char	ased 2016 Ve an by d) ne by t all tions I the cator iew ation	
	was completing the 1 #98 she had been un documentation of a di record for the use of 3 that Resident #98 wa on 9/23/16 and admit MDS Nurse reported discharged from the h the facility on 9/28/16 the Seroquel. She in the physician's comm a diagnosis related to not received a respon diagnosis for a medic	agnosis in the medical Seroquel. She explained s discharged from the facility ted to the hospital. The when Resident #98 was hospital and readmitted to that he had been ordered dicated she documented in unication book a request for the Seroquel, but she had use. She stated that typically		Nurses on weekends, to assure all medications have an appropriate diagnosis for use to include antipsych medications. All concerns will be rep to the attending physician for correcti Monitoring will occur weekly x 2 week then twice weekly x 2 weeks, then we x 4, then monthly x 1 month. The Dir of Nursing will review and initial the a x 2 weeks, then twice weekly x 2 week then weekly x 4, then monthly x 1 mo for trends and concerns. 4.) The Director of Nursing will present the results of the monitoring to the Executive Quality Assurance Commit monthly x 3 for trends and the need for continued monitoring.	orted on. as, eekly ector udits eks, nth ent	

I ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		JULTIPLE CONSTRUCTION ILDING		
		345051	B. WING			C	
	ROVIDER OR SUPPLIER EALTH AND REHABILIT		B. Wille	STREET ADDRESS, CITY, STAT 405 SOUTH GREENE STREE WADESBORO, NC 28170	ET .	10/20/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA FICIENCY)	DATE	
F 329	and reported there we diagnosis for Seroque. The interview with the She explained that we initially admitted to the Seroquel and she had clinical indication at the reported Resident #98 was on the Seroquel stated Resident #98 several months ago. when Resident #98 reported with nother than the Seroquel with nother medical record. The revealed that to her we displayed no behavior. An interview was confurse (RN) Manager She revealed Reside indication for the use Resident #98 had not and no diagnosis down Manager #1 indicate initially admitted to the (4/3/15) he was on She revealed that the time either. Resident #98 had not at that time either.	dent #98's medical record as no documentation of a el. e MDS Nurse continued. Then Resident #98 was be facility (4/3/15) he was on do not known the diagnosis or that time either. She was discontinued and had not known. She are seroquel was discontinued. The MDS Nurse indicated eturned from the hospital and 9/28/16 he was put back on documented diagnosis in and the MDS Nurse additionally knowledge Resident #98 had for sor signs of psychosis. Inducted with Registered and the first on 10/19/16 at 4:55 PM. The first was put back on the first was behaviors, no psychosis, cumented for Seroquel. She stated behaviors, no psychosis, cumented for Seroquel. RN did when Resident #98 was the facility from the hospital eroquel. She revealed diagnosis for the Seroquel. N Manager #1 stated the sident #98 why he was on	F	329			
	She indicated Reside	N Manager #1 continued. ent #98 was hospitalized on n readmitted to the facility on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L , LIDENTIEICATION NITIMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345051	B. WING _			C 0/20/2016	
	NAME OF PROVIDER OR SUPPLIER ANSON HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CO 405 SOUTH GREENE STREET WADESBORO, NC 28170	•	0/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 329	medication list inclushe indicated she indicated she utilized the medicat #98's previous hos utilizing the current from the facility whithere on 9/23/16. It is situation had happed occasions when rehospital with medication list readmission. She indicated the medication list readmission. She documentation in Formal of a diagnosis for Standard to or what it the Seroquel without medical record. The contacted. An interview was conversely was conversely medical the 10/19/16 to obtain for Resident #98. So for are, dated 10/1 #98 had diagnoses psychosis for the urevealed the physicidiagnosis for the Sindicated the diagnosis f	d the hospital discharge uded Seroquel 50mg at bed. thought the hospital had tion list that was from Resident pital admission rather than medication list that was sent en Resident #98 was admitted RN Manager #1 revealed this ened on multiple other sidents returned from the ation lists that were no longer ated the physician reviewed after Resident #98's revealed there was still no Resident #98's medical record	F	329			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WING				C	
NAME OF PE	ROVIDER OR SUPPLIER	0.000.	1	_	STREET ADDRESS, CITY, STATE, ZIP CODE	10/	20/2016	
	to the Little of the Little				405 SOUTH GREENE STREET			
ANSON H	EALTH AND REHABILITA	ATION			WADESBORO, NC 28170			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 329	Continued From page	<u> </u>	F	329				
		I. Resident #98 indicated he	'	020				
		e was prescribed Seroquel.						
	_	o mental health issues that						
	required the use of ar	ntipsychotics.						
	A phone interview wa	s conducted with the						
	physician on 10/20/16							
		esident #98 was initially						
	_	/ (4/3/15) on the Seroquel						
		Gradual Dose Reduction						
		y a mental health provider. ed that when Resident #98						
		the hospital on 9/28/16 that						
		tiated the Seroquel. He						
	indicated the discharg	-						
		ided much information as to						
	had decided to keep l	s restarted. He stated he						
		hile and then planned on						
	completing another G							
	revealed he added th							
		is on 10/19/16 after the						
		ut to him that there was no						
	Seroquel.	#98's medical record for						
F 406	•	OBTAIN SPECIALIZED	F.	406			11/15/16	
SS=D	<u>` </u>	OD IT THE COLOUR LIZED	'	700	,		11/10/10	
	If enecialized rehabilit	tative services such as, but						
	-	al therapy, speech-language						
		nal therapy, and mental						
	health rehabilitative s	ervices for mental illness						
	and mental retardatio							
		sive plan of care, the facility						
		uired services; or obtain the nan outside resource (in						
		3.75(h) of this part) from a						
	_	d rehabilitative services.						
	•							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345051	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	040001		STREET ADDRESS, CITY, STATE, ZIP COI		0/20/2016	
NAIVIE OF P	ROVIDER OR SUPPLIER				DE		
ANSON H	EALTH AND REHABI	LITATION		405 SOUTH GREENE STREET			
				WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 406	Continued From p	page 31	F 4	06			
	by:	ENT is not met as evidenced					
		review, responsible party		Disclaimer Clause:			
		ff interview, the facility failed to		Preparation and or execution			
	obtain a psychiatric consultation as ordered to address the assaultive behavior of 1 of 1			does not constitute admissio			
				agreement by the Provider o			
	,	nt #8) reviewed for		the facts alleged or conclusion			
		eening and Resident Review		the statement of deficiencies			
	(PASKK) Level II.	The findings included:		prepared and or executed so it is required by the provision			
	Docidont #9 was i	nitially admitted to the facility on		and Federal law.	is of the State		
		ple diagnosis that included		and rederanaw.			
		xiety, and depression.		F406			
	oomzopinioma, an	wety, and depression.		1.) The Guardian for Resider	ot #8 agreed		
	A review of Reside	ent #8's medical record		on 10/25/16 for the resident			
		current PASRR level II		the facility outside psychiatric			
		2/22/16) related to a serious		The scheduling of the appoir			
	mental illness.	,		discussed with Resident #8 b			
				Worker on 10/25/16. An app	ointment as		
	The quarterly Min	imum Data Set (MDS)		a walk-in was scheduled for	the resident		
	assessment dated	d 1/15/16 indicated Resident		with the psychiatric services	for 10/26/16.		
	_	s intact. He was coded as		The resident was seen by the	e outside		
		cal behaviors 1 to 3 days during		service on 10/26/16. The res			
	T	view period. Resident #8 had		reported he would follow me			
		d antipsychotic medication,		evaluation through the nursir	-		
		ation, and antidepressant		The facility□s Pharmacist wil			
		f 7 days during the MDS review		resident □s medications on th			
	period.			visit and report recommenda			
	Posidont #0's ma	st recent mental health		facility. The resident will be a newly contracted in-house page 1	•		
		dated 1/20/16. The Psychiatric		service before the end of No	•		
		rse Practitioner (PMHNP)		2.) A 100% audit was complete			
		t #8 was diagnosed with		11/8/16 by the Admissions C			
		xiety, and depression. The		identify any resident with a P			
		cated staff had reported		(Pre-Admission Screening a			
		ty/agitation and continued		Review). No other residents			
		ident #8. The PMHNP indicated		identified in the facility. The F			

AND PLAN OF CORRECTION IDENTIFICATION I		` IDENTIFICATION NUMBED: ` ´		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WING			C 10/20/2016		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	10/2	20/2010	
4 NIO O NI III		T4TION		405 SOUTH GREENE STREET				
ANSON H	EALTH AND REHABILI	IATION		WADESBORO, NC 28170				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 406	continued monitoring persistent or worsen The plan of care for	tt #8's treatment included g and notification to her of led behaviors. Resident #8, included the	F 4	Clinical Manager provided the Admissions Coordinate resident/Responsible Part for in-house psychiatric se admission, obtain a physic	or to include a by consent for ervices on cian⊡s order t	a m for		
	associated with schi plan of care, initiated updated on 4/30/16, level II PASRR. The part, the administrat medication) and Ser medication) for the t the administration of ordered for the treat to a mental health p evaluation of behavi			treatment, and promptly fathe in-house psychiatric set for treatment in the facility 3.) Utilizing a PASRR (Prescreening and Resident Radmission Quality indicate Social Worker will review admissions. This will ident admitted with a PASRR II Screening and Resident Rassure psychiatric treatment, and the psychiatric treatment, and the psychiatric streatment, and the psychiatric streatment, and the psychiatric treatment, and the psychiatric streatment, and the psychiatric streatment.	ax the consentervices provided to the consenter of the consents are the co	at to der the on are		
	The quarterly MDS dated 4/13/16 indicated Resident #8 had moderately impaired cognition. He was coded as having had verbal behaviors 1 to 3 days during the 7 day review period. Resident #8 had been administered antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period. A nursing note dated 6/15/16 indicated when Resident #8 was at activities he went up to the preacher after services were over. The note continued on stating the volunteer went to see what was wrong and Resident #8 punched him in the stomach. Resident #8 reportedly stated, "well he should not have come over there." A Nurse Practitioner (NP) note dated 6/15/16 indicated the chief complaint/nature of presenting problem for the visit with Resident #8 was "hit volunteer." The NP indicated Resident #8 had a			notified for treatment. Mo occur Monday through Frithen, twice weekly x 2 week x 4 weeks, then monthly x The Administrator will revolution tool weekly x 8, then monthereds and concerns. 4.) The Administrator will presults of the monitoring to Quality Assurance Commit for trends and the need for monitoring.	day x 2 weekseks, then weeks 1. iew the audit thly x 1 for present the the Executivitee monthly is	ekly		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345051	B. WING		C 10/20/2016		
	NAME OF PROVIDER OR SUPPLIER ANSON HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170	10/20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 406	episodes of being codocumented, "He was last year due to his of hallucinations. Staff struck volunteer in the would not let him tall service." The NP's posychiatric consultation. A physician's order of psychiatric referral for Resident #8. There was no document consultation for Resident #8. There was no document consultation for Resident #8. There was no document for the service in the face, the arm. The annual MDS danged Resident #8 had mond He was coded as had on 1-3 days during the theorem in the face, the arm. The annual MDS danged had no he was coded as had on 1-3 days during the behaviors were significant risk for phenal been administer antianxiety medication on 7 of 7 period. The Care Area Assee #8's 7/12/16 MDS in areas of mood state psychotropic drug uses the service of the service of the was psychotropic drug uses the service of the was serviced in the service of the was coded as had on 1-3 days during the was coded as had on 1-3 days d	enia with hallucinations and	F 406				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345051	B. WING _			C 10/20/2016		
	ROVIDER OR SUPPLIER	ATION		STREET ADDRESS, CITY, STATE, ZIR 405 SOUTH GREENE STREET WADESBORO, NC 28170	CODE	10/20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 406	based MH provider. CAA indicated Resid hitting staff on 7/9/16 injury. Resident #8 v schizophrenia, anxie potential for fluctuation. The psychotropic druindicated the uses of medication), Seroque Haldol (antipsychotic (antidepressant med noted to have combar 7/12/16 MDS assess noted to have episoconthat had not occurred period. The psychot indicated Resident # mental health as need behaviors and the mof current medication. A nursing note dated #8 was made aware with a community MH. A SW note dated 7/2 a call from Resident The RP indicated the located close to the form to see Resident #8 do reported Resident #8 do reported Resident #8 do reported at the community occated in his home of the see the seed of the seed o	as needed at a community The behavioral symptoms ent #8 had an episode of that placed others at risk for vas noted with diagnoses of ty, and depression and the ons in behaviors and mood. In guse CAA for Resident #8 Klonopin (antianxiety el (antipsychotic medication), emedication), and Cymbalta dication). Resident #8 was utive behaviors during the ment period and he was also des of delusional behaviors diduring the assessment ropic drug use CAA also 8 was to be referred to ded for the management of conitoring of appropriateness	F	406				
	MH provider so he w	nce and with the community as able to be seen for at the provider located close						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345051	B. WING		10/20/2016	
	NAME OF PROVIDER OR SUPPLIER ANSON HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170	10/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 406	Continued From pa	ge 35	F 406	5		
	a call from Residen local community MI exception and was insurance at their local indicated Resident appointment set up the RP and she was the date and time some provide transportation. A nursing note date informed by Speech #8 was yelling at ar to leave the therapy staff, and was hitting. A Patient at Risk (Pindicated Resident antipsychotic medic of schizophrenia. To continued to have soften accused staff. A nursing note date #8 had auditory and delusions. An NP note dated 9 was seen due to a line saw and heard him was reported by star Resident #8 was incommunication.	d 8/20/16 indicated she was in Therapy (ST) that Resident nother staff member, refusing a department, was mocking g himself in the chest. AR) note dated 8/25/16 #8 continued to receive sations related to a diagnosis the note reported Resident #8 some paranoid behaviors and of taking various items. d 9/25/16 indicated Resident divisual hallucinations and hallucinations and his parents and his dog. This lift two nights in a row. dicated to be taking his cted. No changes were				
		dated 10/5/16 indicated oderate cognitive impairment.				

NAME OF PROVIDER OR SUPPLIER ANSON HEALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) F 406		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	RIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER ANSON HEALTH AND REHABILITATION (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 406 Continued From page 36 He was coded as having had behavioral symptoms not directed toward others on 1 to 3 days during the 7 day MDS review period. Resident #8 had been administered antipsychotic medication, antianxiety medication, and antidepressant medication, and antidepressant medication, and verbal behaviors directed toward staff. A nursing note dated 10/16/16 indicated Resident #8 had auditory hallucinations, agilation, and verbal behaviors directed toward staff. A nursing note dated 10/18/16 indicated Resident #8 had hitting and kicking behaviors as well as agitation. A SW note dated 10/18/16 indicated she had left a voicemail message for Resident #8's RP reporting he had not had any outbursts or issues lately that were indicative a need for further MH evaluation. The SW note additionally indicated			345051	B. WING			C 10/20/2016	
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 406 Continued From page 36 He was coded as having had behavioral symptoms not directed toward others on 1 to 3 days during the 7 day MDS review period. Resident #8 had been administered antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period. A nursing note dated 10/10/16 indicated Resident #8 had auditory hallucinations, agitation, and verbal behaviors directed toward staff. A nursing note dated 10/16/16 indicated Resident #8 had hitting and kicking behaviors as well as agitation. A SW note dated 10/18/16 indicated she had left a voicemail message for Resident #8's RP reporting he had not had any outbursts or issues lately that were indicative a need for further MH evaluation. The SW note additionally indicated			ATION	405 SOUTH GREENE STREET		CODE	10/20/2010	
He was coded as having had behavioral symptoms not directed toward others on 1 to 3 days during the 7 day MDS review period. Resident #8 had been administered antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period. A nursing note dated 10/10/16 indicated Resident #8 had auditory hallucinations, agitation, and verbal behaviors directed toward staff. A nursing note dated 10/16/16 indicated Resident #8 had hitting and kicking behaviors as well as agitation. A SW note dated 10/18/16 indicated she had left a voicemail message for Resident #8's RP reporting he had not had any outbursts or issues lately that were indicative a need for further MH evaluation. The SW note additionally indicated	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	COMPLETION	
she had informed the RP that if a need for an MH appointment arose that she would inform her. An interview was conducted with the Marketing Director on 10/18/16 at 3:20 PM. She indicated she was previously the SW at the facility. She stated Resident #8 was seen by psychiatric services in the past. She indicated the facility used to have an MH provider who came to the facility to see residents. She stated that MH provider ceased their services at the facility several months ago. She indicated she needed to look into the records to find out the actual date the MH provider stopped providing services at their facility. A follow up interview was conducted with the	F 406	He was coded as ha symptoms not directed days during the 7 da Resident #8 had bee medication, antianxia antidepressant medication, antianxia antidepressant medicated #8 had auditory hallowerbal behaviors directly a had hitting and king agitation. A SW note dated 10/a voicemail message reporting he had not lately that were indicevaluation. The SW she had informed the appointment arose the An interview was cordirector on 10/18/16 she was previously the stated Resident #8 were services in the past. Used to have an MH facility to see resider provider ceased their several months ago. to look into the record the MH provider stop their facility.	ving had behavioral ed toward others on 1 to 3 by MDS review period. In administered antipsychotic ety medication, and cation on 7 of 7 days during od. 10/10/16 indicated Resident actinations, agitation, and ected toward staff. 10/16/16 indicated Resident extended toward staff. 10/16/16 indicated Resident extended toward staff. 18/16 indicated she had left extended toward staff and any outbursts or issues active a need for further MH note additionally indicated extended toward staff. 18/16 indicated she had left extended to a need for an MH note additionally indicated extended to the swould inform her. 18/16 indicated the facility. She indicated the facility provider who came to the extended to the facility she indicated she needed do to find out the actual date oped providing services at	F	106			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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ANSON H	EALTH AND REHABILITA	ATION		V	VADESBORO, NC 28170		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 406	Continued From page	e 37	F	406			
		vider who used to come into					
		ed their services at the					
		She reported that after					
		olan was to utilize the local					
		der for psychiatric treatment					
		ed. The physician's order for					
		15/16 for a psychiatric					
	consultation for assau	ultive behaviors was					
	reviewed with the Ma	rketing Director. The					
	medical record that c	ontained no evidence of a					
	psychiatric consultation	on for Resident #8 following					
		's order was reviewed with					
		or. She indicated she was					
	responsible for coord						
		of 6/15/16 physician's order.					
		nembered this physician's					
		or a psychiatric consultation					
		nursing note dated 7/13/16 nt #8 was made aware of a					
	provider for 7/21/16 v	ent with a community MH					
	·	She reported she recalled					
		type of insurance problem					
	with the local commu						
		been seen for a psychiatric					
		as unable to explain why the					
		the psychiatric consultation					
		dated 6/15/16 and the first					
	documentation in the	medical record regarding					
	the psychiatric appoir	ntment was on 7/13/16 when					
	the appointment was	indicated to be scheduled					
	for 7/21/16. The Mar	keting Director indicated that					
		nist was the person who					
	scheduled all of the a						
		tionist and current SW be					
	interviewed for addition	onal information.					
	An interview was sen	ducted with the SW on					
		She stated she began					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345051	B. WING			10/	20/2016	
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
лисОи ⊔	EALTH AND REHABIL	ITATION		405 S	OUTH GREENE STREET			
ANSON II	EALIN AND RENABIL	HATION		WAD	ESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 406	she shadowed the Marketing Director the facility. The ph dated 6/15/16 for a assaultive behavior indicated that althowork at the facility was aware of the reported there were insurance being and MH provider. She insurance an appoint 7/21/16 at the comhis home county. explain why the phrysychiatric consults dated 6/15/16 and medical record regappointment was in 7/21/16. The SW why there was no predical record of the appointment. She any records from the Resident #8. She she medical record #8's RP for addition. An interview was con 10/19/16 at 8:45 an electronic calendar for Resident #8 was community MH produced.	ity on 7/11/16. She reported previous SW/current when she began working at hysician's order for Resident #8 psychiatric consultation for rs was reviewed the SW. She had not begun to at the time of the referral, she referral for Resident #8. She resident #8 she had not begun to at the time of the referral, she referral for Resident #8. She resident #8 she resident #8 she resident #8 she resident was scheduled for munity MH provider located in The SW was unable to resident #8 was the first documentation in the redicated to be scheduled for was also unable to explain progress note in Resident #8's the 7/21/16 psychiatric indicated she never received the community MH provider for stated she needed to review and follow up with Resident	F	406				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345051	B. WING _			C 10/20/2016	
	ROVIDER OR SUPPLIER	ATION		STREET ADDRESS, CITY, STATE, ZIP CO 405 SOUTH GREENE STREET WADESBORO, NC 28170	ODE	10/20/2010	
(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 (X (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 406	Continued From page to the local communit Resident #8's insurar indicated the next docalendar related to the for Resident #8 was cappointment was sch provider in his home Receptionist was una 6/17/16 psychiatric al was cancelled on 6/1 appointment was not A second interview won 10/19/16 at 9:08 A had obtained addition events that occurred ordered the psychiatric She stated that on 6/transported by the family family for a sch appointment. She stated that on sch appointment. She stated psychiatric consultation. The local MH provider to go to the community indicated to go to the community for the side of the community for the side of the community for the local MH provider to go to the community for the side of the community for the local formula in the local MH provider to go to the community for the local means the loc	e 39 by MH provider not accepting once. The Receptionist cumentation in the electronic e psychiatric appointment on 7/13/16 when an eduled at a community MH county on 7/21/16. The able to explain why the expointment for Resident #8 7/16 and another scheduled until 7/13/16. as conducted with the SW of the SW indicated she all information regarding the after Resident #8 was ic consultation on 6/15/16.					
	community MH provided home county. On 7/2 transportation for Reseappointment at the collocated in his home commet him at the 7/21/1 appointment was for a psychiatric consultar Resident #8. At this asked by the provided being seen at the corresponding to the provided here.	21/16 for Resident #8 at the der that was located in his 21/16 the facility provided sident #8 to attend the ommunity MH provider ounty. Resident #8's RP 6 appointment. This an informational intake and ation was not provided for appointment the RP was r why Resident #8 was not munity MH provider that the facility. The RP then					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	IPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ATION		STREET ADDRESS, CITY, STATE, ZIP COD 405 SOUTH GREENE STREET WADESBORO, NC 28170	•	10/20/20 10		
(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 CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 406	worked to coordinate and the community M to be made so Reside at the community MH facility. This coordinate according to the SW. #8's RP had informed that the local community on 8/19/16 no psychia scheduled for Reside RP scheduled Reside that she was able to a indicated Resident #8 behaviors that require so she had not inform appointment needed confirmed Resident # psychiatric consultatic physician on 6/15/16. A phone interview wa #8's RP on 10/19/16 occurred after Reside psychiatric consultatic with his RP. She indit the appointment that at the local communit #8. She stated she happointment was not community MH provide home county. The Resident #8 at the 7/2 confirmed this appointment intake a seen for a psychiatric that after the 7/21/16 coordinated with the interview with the interview that after the 7/21/16 coordinated with the interview with the interview was not community which are consultating that after the 7/21/16 coordinated with the interview with the interview was not community which are consultating with the interview was not community which are consultating with the interview was not community which are consultating with the interview was not community which are consultating with the interview was not community which are consultating with the interview was not community which are consultating with the interview was not community which wa	with the insurance company IH provider for an exception ent #8 was able to be seen provider located near the ation took several weeks She indicated Resident II her by phone on 8/19/16 mity MH provider had agreed ce. At the time of phone call atric consultation had been int #8. The SW stated the ent #8's appointments so attend them. The SW IS had not had any additional ed a psychiatric consultation ned his RP that an it to be scheduled. The SW IS was not seen for a in as ordered by the int #8 was ordered by the int #8 was ordered in Resident #8's Preported she had met intend was for an int int Resident #8 was not intend inte	F4	406				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345051	B. WING			10/	20/2016
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ANSON H	EALTH AND REHABILITA	ATION			105 SOUTH GREENE STREET		
				١	WADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 406	to be seen at the corr closer to the facility. coordination took seen had contacted the SV completed. The RP is to let her know if a ps needed to be schedu stated the SW had not #8 needed a psychiat The interview with Re She discussed Resider behavior in the past. had an inpatient psychiat An interview was con Nursing (DON) on 10 reported her expectat orders to be followed physician wrote an or consultation that she be obtained. The phy for a psychiatric cons assaultive behavior w She stated that was a with Resident #8's ins MH provider. She inc psychiatric consultatio because there were r Resident #8 assaultir 483.75(o)(1) QAA	Immunity MH provider located The RP indicated the eral weeks. She stated she when coordination was indicated she asked the SW ychiatric appointment led for Resident #8. She of informed her that Resident ric appointment. Issident #8's RP continued. Issident #8's psychiatric history. In the had combative She indicated Resident #8 hiatric hospitalization that boths that was initiated due avior. Inducted with the Director of 19/16 at 3:50 PM. She ion was for physician's Indicated if a der for a psychiatric expected the consultation to resician's order dated 6/15/16 ultation for Resident #8's reas reviewed with the DON. Inware there had been issues surance and the community dicated she thought the on was never obtained and additional incidents of anybody else. ERS/MEET		406 520			11/15/16
	reported her expectate orders to be followed physician wrote an orconsultation that she be obtained. The physician psychiatric consultative behavior with Resident #8's insum MH provider. She inconsultative because there were resident #8 assaultir 483.75(o)(1) QAA COMMITTEE-MEMB	cion was for physician's She indicated if a der for a psychiatric expected the consultation to visician's order dated 6/15/16 ultation for Resident #8's vias reviewed with the DON. It was there had been issues surance and the community dicated she thought the on was never obtained no additional incidents of rig anybody else. ERS/MEET	F	520			11/15/16

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER	ATION		4	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTH GREENE STREET VADESBORO, NC 28170		
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F 520	assurance committee nursing services; a ph facility; and at least 3 facility's staff. The quality assessment committee meets at least assues with respect to and assurance activities develops and implement action to correct identification and assurance activities develops and implement action to correct identification action to correct quality deals a basis for sanctions. This REQUIREMENT by: Based on record revision action actio	in a quality assessment and consisting of the director of hysician designated by the other members of the ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of tified quality deficiencies. Eary may not require ords of such committee the disclosure is related to the formittee with the fection. The total property of the disclosure is related to the ordinate with the fection. The total property of the committee to identify efficiencies will not be used as The is not met as evidenced few, observations, and staffer is Quality Assessment and mmittee failed to maintain the and monitor these committee put into place of the property of the committee in the information of the conformation of the c	F	520	Disclaimer Clause: Preparation and or execution of this pladoes not constitute admission or agreement by the Provider of the truth the facts alleged or conclusion set forth the statement of deficiencies. The plar prepared and or executed solely because it is required by the provisions of the Stand Federal law. F520 The facility will monitor and evaluate effectiveness of the identified QAPI	of n on n is use	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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лисом п	EALTH AND REHABILITA	ATION		405 SOUTH GREENE STREET				
ANSON II	EALIN AND RENADILII	ATION		W	ADESBORO, NC 28170			
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F 520	Continued From page survey of 10/20/2016 the facility during two show a pattern of the an effective Quality A program. The findings This tag is cross refer 1. F278 - Assessmer record review and state to code the Minimum assessment accurate (Resident #92) of 1 state (Resident #93) of 1 state (Resident #94) of 1 state (Resident #9	e 43 The continued failure of federal surveys of record facility 's inability to sustain seessment and Assurance included: renced to: nt Accuracy: Based on finterview, the facility failed Data Set (MDS) ly on prognosis for 1 ampled resident receiving for failing to accurately ation and therapy services current recertification survey y failed to code accurately MDS. ticipate Planning an: Based on medical record view, the facility failed to be reflect the diet order of on August physician 's e residents reviewed for 4). cion survey of 11/19/2015 the D for failing to review and		520		for S e of tte an 16 e ttify er as		
	resident who had bila discontinued and faili care plan for another psychotropic medicat recertification survey failed to revise the ca order of pureed diet. 3. F329 Drug Regime drugs: Based on med staff, nurse practition	teral hand splints ng to review and revise a resident who was receiving			Audit Tool, the ADON will review all physicians orders for new orders for Hospice services to assure the residen MDS was properly coded correctly for the prognosis question. Monitoring will occur weekly x 4 weeks, then twice monthly a month, then monthly x 1. The Director Nursing will review the QI Audit Tool weekly x 4 weeks, then twice monthly a month, then monthly x 1 for trends and concerns.	t⊟s the cur k 1 of		

NAME OF PROVIDER OR SUPPLIER ANSON HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESS, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESS, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESSOR, NO. 28170 PRICE STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESSOR, NO. 28170 PRICE STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESSOR, NO. 28170 PRICE STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESSOR, NO. 28170 PRICE STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESSOR, NO. 28170 PRICE STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESSOR, NO. 28170 PRICE STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESSOR, NO. 28170 PRICE STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESSOR, NO. 28170 PRICE STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESS, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESSO, NO. 28170 PRICE STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESSO, TOR 28170 PRICE STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESSO, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESSO, CITY, STATE, ZIP CODE 408 SOUTH GREEN STREET WADDRESSOUTH ACTION SINCULO BE CROSS-REPERSENCED TO THE APPROPRIATE WADDRESSOUTH TO THE APPROPRIATE W	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
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ANSON HEALTH AND REHABILITATION SUMMARY STATEMENT OF DEPICIENCIES GEACH DEPICIENCY MUST BE PRECEDED BY FULL RESOLUTION OF DEPICE ACTION SHOULD BE CARD FOR MUST BE DEPICED FOR THE PRECEDED BY FULL REPORT OF DEPICE ACTION SHOULD BE CARD FOR MUST BE DEPICED FOR THE PRECEDED BY FULL REPORT OF DEPICE ACTION SHOULD BE CARD FOR MUST BE DEPICED FOR THE PRECEDED BY FULL REPORT OF DEPICE ACTION SHOULD BE CARD FOR MUST BE DEPICED FOR THE PRECEDED BY FULL REPORT OF DEPICE ACTION SHOULD BE CARD FOR MUST BE DEPICED FOR THE PRECEDED BY FULL REPORT OF DEPICE ACTION SHOULD BE CARD FOR MUST BE DEPICED FOR THE PRECEDED BY FULL REPORT OF DEPICE ACTION SHOULD BE CARD FOR MUST BE DEPICED FOR MUST BE DEPICEDED BY FULL REPORT MUST BE DEPICEDED BY FULL REPORD MUST BE DEPICEDED BY FULL REPORT BY FULL			345051	B. WING _			10	/20/2016
ANSON HEALTH AND REHABILITATION MADESBORO, NC 28170	NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE		-	
MAJESSORO, NC 28170			_		40	05 SOUTH GREENE STREET		
FS20 Continued From page 44 the administration of an antipsychotic medication for 1 of 5 residents (Resident #38) reviewed for unnecessary medications. During the recertification survey of 11/19/2015 the facility was cited F329 for failing to utilize non pharmacological approaches to address behaviors, failed to evaluate the underlying cause of behaviors either before or during treatment with antipsychotic medication and failing to reassess the ongoing clinical indication for antipsychotic medication in the absence of a clinical indication. On the current recertification survey of 10/20/2016, the facility failed to have a clinical indication for the administration of an antipsychotic medication. An interview was conducted with the Administrator on 10/20/2016 at 11:00 AM. She made me aware, that as the administrator, her role was being the head of the facility's QAA committee. She provided further information that the QAA Committee consisted of the Medical Director, Director of Nursing (DON), Dietary Manager, Recreation Services Manager, Social Worker, Environmental/Laundry Manager, Maintenance Director, rehabilitation Director, and the Pharmacist. She stated the committee met monthly. The Administrator was aware that assessment accuracy, right to participate in planning care-revise care plan, and that the resident's drug regimen was free from unnecessary drugs were repeat deficiencies from the previous receitification survey. She informed me that the facility QAA committee that had developed and implemented appropriate plans of action to correct identified quality deficiencies from the reviewed.	ANSON H	EALTH AND REHABI	LITATION		W	ADESBORO, NC 28170		
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correct identified quality deficiencies from the last survey. The QAA committee had reviewed then monthly x 1 month for trends or concerns.			•				ty	
survey. The QAA committee had reviewed concerns.						_		
E279 accommont accuracy E290 right to							nt.	
F278-assessment accuracy, F280-right to participate in planning care-revise care plan, and 4.) The Director of Nursing will present the results of the monitoring to the							11	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345051	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	040001	1 3	STREET ADDRESS, CITY, STATE, ZIP CODE	10	/20/2016	
				405 SOUTH GREENE STREET			
ANSON H	EALTH AND REHABILIT	ATION		WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	JLD BE	(X5) COMPLETION DATE	
F 520	drugs. The QA commodeficiencies from the	s free from unnecessary nittee reviews all of the last survey. If there were identified then the issue	F	Executive Quality Assurance Commonthly x 3 for trends and the need continued monitoring. F329 1.) The resident #98 received a conformation for use of Seroquel and the care pupdated on 10/19/2016 by the ME Nurse. The resident #98 was examined assessed by the attending Phon 10/25/16 and new orders were received to discontinue the use of Seroquel. The order was carried the care plan was updated by the Nurse on 10/25/16. 2.) A 100% audit of all residents psychoactive medications was conon 11/8/16 by Nursing Administrations that orders with diaground was documented for use of the medication. The audit revealed the medication orders for appropriate diagnoses were completed as need All residents without an acceptable diagnosis orders were written to clarify the understand the medication on or before 11/10 Nursing Administration. A 100% I staff in-service was initiated on 11 by ADON to assure all medications appropriate diagnosis and complete 11/11/16. The in-service included full-time, part-time and prn (as neuroses. Any new orders written to weekends will be addressed by the Charge Nurse on duty with follow-	iagnosis lan was S hined ysician but and MDS receiving inpleted tion hosis at all oses. ded. edical New se of 16 by censed 19/2016 is to have an red by all eded) in the edical second the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(2	(X3) DATE SURVEY COMPLETED		
		345051	B. WING _			C 10/20/2016		
	ROVIDER OR SUPPLIER EALTH AND REHABILIT	ATION		STREET ADDRESS, CITY, STATE, ZIP 405 SOUTH GREENE STREET WADESBORO, NC 28170	CODE	10/20/2010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE		
F 520	Continued From pag	e 46	F5	the DON/ADON as needed managers will also check orders including psychotron have an appropriate diagram Medication Administration newly hired licensed staff education during orientations. Jutilizing a Diagnosis Audit Tool, the Unit Manarall new physicians order Monday through Friday an Nurses on weekends, to medications have an appropriate appropriate to the attending physician Monitoring will occur week then twice weekly x 2 weeks x 4, then monthly x 1 mor of Nursing will review and x 2 weeks, then twice week then weekly x 4, then monfor trends and concerns. 4.) The Director of Nursither results of the monitoring Executive Quality Assurant monthly x 3 for trends and continued monitoring. If identified QAPI (Qualither Performance Improvement program will and revised as necessary related Quality Insurance Performance Improvement programs will remain in expensive the surface of the provement programs will remain in expensive the program will and the program will remain in expensive the program will program will remain in expensive the program will program w	to be sure all ropic medication nosis on the necord. All f will receive the ion. Quality Indicate gers will review rs for medication the Charge passure all propriate de antipsychotics will be reported in for correction. Rely x 2 weeks, eks, then week in the The Direct of initial the auditekly x 2 weeks, nthly x 1 month ing will present ing to the need for the need for ty Insurance annt) programs esholds, the erformance II be reevaluate y. All survey and nt monitoring	or von		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345051	B. WING			400	
NAME OF PI	ROVIDER OR SUPPLIER	040001		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	10/.	20/2016
				405 SOUTH GREENE STREET			
ANSON H	EALTH AND REHABILITA	ATION		WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 520	Continued From page	÷ 47	F	monitoring and review for a minimum of 6 months. The or Department Head respon completing identified audits the results of those audits to Assurance Performance Imp Committee monthly for 3 months quarterly x1, and then at the frequency determined by the	Administration is a sible for will present to the Quality provement on this, then a need	t y	