PRINTED: 11/21/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 10/11/2017	
	ROVIDER OR SUPPLIER DHEALTH & REHABILITA	ATION CO		STREET ADDRESS, CITY, STATE, ZIP COD 2702 FARRELL ROAD SANFORD, NC 27330		10/11/2017	
(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 157 SS=D	(INJURY/DECLINE/R CFR(s): 483.10(g)(14) (g)(14) Notification of (i) A facility must immonsult with the residuation of the consistent with his or representative(s) where the consistent injury and his physician intervention. (B) A significant chan mental, or psychosocy deterioration in health status in either life-throclinical complications. (C) A need to alter the annead to discontinue treatment due to advect the commence and the facility and the facility when the facility with the consistent from the facility with the consistent informatic is available and proving physician. (iii) The facility must a resident and the resident when there is-	COOM, ETC) Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring t; ge in the resident's physical, ial status (that is, a ental, or psychosocial reatening conditions or		TITLE		11/6/17	

10/30/2017 **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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345534	B. WING		C 10/11/2017	
NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		10/11/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 157	Continued From pag		F 157			
	as specified in §483. (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must update the address (phone number of the This REQUIREMENT by: Based on record revinterview and staff in notify the physician of blood glucose and rewhich resulted in a dhospitalization for 1 or reviewed for nutrition #1). Findings included: Resident #1 was addresident #1 was	dent rights under Federal or ons as specified in paragraph in. record and periodically mailing and email) and resident representative(s). To is not met as evidenced view, physician 's assistant terviews, the facility failed to off the resident 's elevated efusal to take medication elay of treatment and of 3 sampled residents in and hydration (Resident included anemia, es mellitus, and dementia. Jum Data Set dated 7/7/17 in had severely impaired maviors. The resident essistance of total ctivities of daily living (ADL)		F157 Preparation and or execution of this page does not constitute admission or agreement by the Provider of the trut facts alleged or conclusion set forth of statement of deficiencies. The plan is prepared and executed solely because is required by the provisions of State Federal law. Nurse #1 was terminated on October 2017 prior to the survey. Nurse #2 received 1:1 education by the Staff Development Coordinator on October 15, 2017. This education included following a physician of specific to Blood Glucose and physician outification. The education also included.	h of on the see it and	
	always incontinent o Diagnoses were diak 's dementia, and dy- received insulin 7 da The resident's care	oetes mellitus, non-Alzheimer sphagia. The resident		notification of a change in condition in change in the residents physical, meror psychosocial status (that is, deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) and notification of physical medication refusals and appropria	ntal,	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			E SURVEY IPLETED
		345534	B. WING		1	C 0/11/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	3/11/2017
				2702 FARRELL ROAD	_	
SANFORE	HEALTH & REHABILIT	ATION CO		SANFORD, NC 27330		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETION DATE
F 157	Continued From pag	e 2	F 15	7		
	hypo and hyperglyce	mia and refusal of care.		documentation of physician n	otification.	
		dated 9/5/17 specified to		Nurse #3 received 1:1 educat		
		00 units/ml according to		Staff Development Coordinate		
		efore meals and at bedtime		October 15, 2017. This educa		
	with sliding scale as	follows:		included notification of physic		
	Blood glucose 0-150	= 0 unito		medication refusals and approduced documentation of physician n		
	Blood glucose 0-150 Blood glucose 151-2			documentation of physician in	Ottilication.	
	Blood glucose 131-2			The Medication Administration	n Records of	
	Blood glucose 251 -			all residents with sliding scale		
	Blood glucose 301 -			glucose checks were audited		
		greater = 10 units and to		Director of Nursing, Staff Dev	•	
	notify the physician	9		Coordinator, and Nurse Unit (
				between October 15, 2017 ar		
	A review of the Septe	ember 2017 Medication		6, 2017 for any instances who		
		d (MAR) revealed on		physician was not notified as		
	9/19/17 at 6:30 am R	lesident #1 ' s blood glucose		within the past (30) days. Any	instances of	
	was recorded as 581	and that 10 units of Novolog		non-compliance were reporte	d to the	
	insulin was administe	ered by Nurse #1.		physician no later than Noven	nber 6, 2017.	
				All licensed nursing staff was		
		#1 's September 2017		by the Staff Development Cod		
	nurses ' notes revea			between the dates of October		
		sident's condition or		and November 6, 2017 regard		
		sician about the 9/19/17 at		the physician with any change		
	6:30 am elevated blo	od glucose of 581.		condition. This education incli		
	A rovious of the Conte	ombor 2017 MAD royalad		following a physician ☐s order Blood Glucose and physician		
		ember 2017 MAR revealed urse #3 that Resident #1		The education also included r		
		m medications on 9/21/17.		a change in condition i.e. a ch		
		entation that the physician		residents physical, mental, or	-	
		resident 's refusal to take his		psychosocial status (that is, d		
	medications.			in health, mental, or psychoso		
				either life-threatening condition		
	The Physician 's Ass	sistant (PA) order dated		complications) and notification		
	•	ntus 10 units every evening		physician for medication refus		
	(increased).			appropriate documentation of		
				notification. Any licensed nurs	se not	
	The PA's order date	d 9/22/17 was to administer		in-serviced by November 6, 2		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345534	B. WING _				C 11/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	10,	11/2017
				27	702 FARRELL ROAD		
SANFORE	HEALTH & REHABILIT	TATION CO		S	ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From pag	ne 3	F 1	157			
	for one dose (given	units/ml inject 10 units now at 3 pm) and to administer			work until in-servicing has been completed.		
	sugar every 2 hours until blood sugar ded discontinue.	unit/ml by checking blood and give 10 units of Novolog creased to 300 and then			In order to provide quality assurance, umanagers or designees will complete a audit to include review of 24-hour report for compliance with notification of the	n rts	
	vital signs were stab ill-appearing. Two a units were administe	ote revealed Resident #1 ' s le and he was afebrile, but dditional doses of Novolog 10 ered in addition to sliding			physician on changes of condition. This audit will be completed daily for two weeks, twice weekly for two additional weeks, and then weekly for two months.	S.	
	reading continued to register on the blood ordered for increase glucose at bedtime.	dinner. Blood glucose register HIGH (too high to I glucometer). The PA d fluids and to re-check blood However, the resident 's ested resident be sent for full			Results of these audits will be presented by the Director of Nursing or Staff Development Coordinator in the Qualit Assurance Performance Improvement meeting for a minimum of three consecutive meetings and on-going as	y	
	evaluation at the hos	spital. The PA ordered to the hospital via emergency evaluation to exclude infection			indicated. The Director of Nursing, Staff		
	or diabetic ketoacido	osis or hyperosmolar etotic syndrome (severely			Development Coordinator, or Unit Managers will monitor the Medication Administration Record for a minimum of (5) residents receiving sliding scaled		
	10/1/17 revealed Re Emergency Departm	ital discharge summary dated sident #1 was sent to the nent on 9/22/17 for severe ared mental status. The			insulin to ensure the physician is notific as ordered. These audits will be completed weekly for four weeks and on-going as indicated. Results of these audits will be presented by the Director	!	
	resident was admitted with the diagnoses of sodium) and central	ed into the intensive care unit of hypernatremia (high diabetes insipidus (diabetic			Nursing or Staff Development Coordina in the Quality Assurance Performance Improvement meeting for any needed		
	renal failure (ARF), a severe dysphagia. A resuscitation, the res range. The ARF res	sident's sodium was normal olved. The resident was hospital on 10/1/17 with an			continuous of monitoring.		

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NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	10/11/2017		
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F 157	desmopressin 10 mc retain water) every eve	g intranasal (aids the body to vening. In pm an interview was acility 's Physician 's PA stated that she was first #1 's elevated blood The PA was not informed by solve blood glucose was 581 in. The PA stated that the elevated was to inform the glucose was greater than atted that she would have formed that the blood glucose was greater than atted that she would have formed that the blood glucose was greater than atted that she would have formed that the blood glucose was greater than attended that the blood glucose was greater than attended that the blood glucose was elevated she would sulin order and ordered labs The PA stated she would sulin order and ordered labs The PA stated she would sulin order and ordered labs The PA stated she would se #2. Nurse #2 was elevated the resident had a blood se #2 stated she g insulin 10 units. Nurse #2 ll the physician and did not. The resident was alert. Ced that the increase in the cose was related to the grormula. Nurse #1 stated the sliding scale for blood er required the nurse to call #1 stated that in retrospect essed the resident for the blood glucose and should	F 15				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157		pm an interview was Director of Nursing (DON).	F 15	7	
F 224 SS=E	the physician ' s orde physician if the resid PROHIBIT	she expected staff to followers as written and to notify the ent refused their medication. EGLECT/MISAPPROPRIATN 0-(3)	F 22	4	11/6/17
	abuse, neglect, misa property, and exploit subpart. This include freedom from corpor seclusion and any pl	thas the right to be free from appropriation of resident ation as defined in this but is not limited to all punishment, involuntary mysical or chemical restraint the resident's symptoms.			
	(b)(1) Prohibit and preside	y must develop and blicies and procedures that: revent abuse, neglect, and ents and misappropriation of			
	resident property, (b)(2) Establish policinvestigate any such	ies and procedures to allegations, and			
	§483.95, This REQUIREMEN by: Based on record rev interview, and Physic facility failed to prote	g as required at paragraph T is not met as evidenced view, resident interview, staff cian's Assistant interview, the ct residents from staff who provide medications as idents reviewed for		F224 □ Nurse #1 was terminated on October 3 2017 and a complaint to the North Carolina Board of Nursing was filed by Director of Nursing on October 9, 2017	the

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345534	B. WING		10	C)/11/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		7/11/2017
				2702 FARRELL ROAD	_	
SANFORE	HEALTH & REHAB	LITATION CO		SANFORD, NC 27330		
040.15	CUMMAD	Y STATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CO	DDECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		I SHOULD BE	(X5) COMPLETION DATE
F 224	Continued From p	page 6	F 2	24		
	medications (Res	idents #2, #13, #14, #15, #16)				
	and tube feeding	as ordered to 1 of 4 residents		On October 3, 2017, Resident	ts (#13, #2,	
	reviewed for tube	feeding (Resident #17). The		#14, #15, #16) omitted medica	ations were	
	findings included:			reported to the physician by the	ne Director	
				of Nursing. The physician dete		
		vas admitted to the facility on		none of the omitted medicatio		
		ple diagnoses that included		in harm of Residents (#13, #2	, #14, #15,	
		abetes Mellitus Type 2, chronic		and #16).		
		yperlipidemia, and		Datus an October 20, 2017 or	al Niassanahan	
	hypernatremia.			Between October 30, 2017 an 3, 2017, all residents with a B		
	The admission Mi	nimum Data Set (MDS)		equal to or higher than 11 wer		
		d 8/18/17 indicated Resident		interviewed by the Director of		
		vas fully intact. He received		Staff Development Coordinate		
	_	edications and as needed pain		Worker to ensure there were		
		sident #13 was administered		instances of neglect including		
	insulin, antidepres	ssant medication, and diuretic		limited to the omission of med		
	medication on 7 c	of 7 days during the MDS look		administration.		
	back period. He	was administered antianxiety				
		of 7 days during the MDS look		Between October 30, 2017 ar		
	back period.			3, 2017 the Responsible Party residents with a BIMS score le		
	_	was completed by Resident #13		were contacted by the Directo	_	
		at occurred on 10/2/17. The		Staff Development Coordinate		
		ievance read, "I never got my		Unit Manager to ensure there		
		s] or insulin". The grievance		additional instances of neglec	-	
	_	findings indicated Resident #13		but not limited to the omission) OT	
		ented. His electronic Medication		medication administration.		
		cord (eMAR) was reviewed and ad been signed out by Nurse		All staff, including: licensed nu	ireae nurea	
		s interviewed by the Director of		aides, dietary, housekeeping,		
		nd was terminated.		administration were in-service		
				Staff Development Coordinate	•	
	A review of Resid	ent #13's physician's orders in		October 15, 2017 and Novem		
		indicated his evening		regarding abuse and neglect.		
		Lantus (insulin), Humalog		in-service included education		
		in (high cholesterol medication),		signs and/or symptoms of abu	•	
	1 '	e pain medication), Tylenol, and		neglect, reporting procedures		
	Sodium chloride.	•		or symptoms are identified, ar	nd	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING _				C 11/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	11/2017	
TO WILL OF T	NOVIDER OR COLL FIER							
SANFORE	HEALTH & REHABILITA	ATION CO			702 FARRELL ROAD			
				<u> </u>	SANFORD, NC 27330			
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 224	Continued From page	e 7	F 2	224				
F 224	A 24-hour initial report facility Administrator in The allegation/incider neglect. The report in occurred on 10/2/17 times of 7:00 PM and description read, "Re [Resident #13] that [Nor offer medications indication of any harm was listed on the report of this notice to administer resident medications as given still in the medication administer tube feeding The 5-working day re AIT on 10/6/17. The neglect referred to in completed on 10/3/17 investigation was continued.	t was completed by the n Training (AIT) on 10/3/17. In type was listed as resident indicated the incident through 10/3/17 between the 17:00 AM. The allegation ceived complaints from Nurse #1] did not administer during shift". There was no into Resident #13. Nurse #1 fort as the accused individual. The with the DON. The indicated Nurse #1 failed its' medications, signed out when the medication was card, and failed to ing as ordered.	F 2	224	notification of the physician. Any staff r in-serviced by November 6, 2017 will r work until in-servicing is completed. In order to provide quality assurance, t Director of Nursing, Staff Development Coordinator, or Nurse Unit Managers v interview a minimum of two residents v a BIMS score equal to or greater than weekly for four weeks and longer if indicated to ensure no additional instances of neglect, including omissio medication administration have occurre Findings of these interviews will be presented in the Quality Assurance Performance Improvement Meeting to determine if results indicate a need for continued monitoring. In order to provide quality assurance, the Director of Nursing, Staff Development Coordinator, or Nurse Unit Managers v observe a minimum of two medication administration passes weekly for four weeks and longer if indicated to ensure additional instances of neglect, including omission of medication administration	he ti vill vith 11 n of ed.		
	The narrative of the in indicated an initial gri Resident #13 that alle administer or offer me scheduled shift of 10/AM. The investigatio eMAR reveals that [N medications for [Resi scheduled shiftduri other residentscom that they too had not	evestigation of neglect evance was received by eged Nurse #1 failed to edications during her (2/17 from 7:00 PM to 7:00 n read, in part, "Review of lurse #1] did not administer			have occurred, and the Medication Administration Record is complete and accurate. Findings of these medication administration observations will be presented in the Quality Assurance Performance Improvement Meeting to determine if results indicate a need for continued monitoring.			

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		IULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING				C	
NAME OF D	ROVIDER OR SUPPLIER	343334	B. WING	QTD!	EET ADDRESS, CITY, STATE, ZIP CODE	10/	11/2017	
NAME OF F	ROVIDER OR SUFFLIER				2 FARRELL ROAD			
SANFORE	HEALTH & REHABILITA	ATION CO			NFORD, NC 27330			
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 224	Continued From page	e 8	f F	224				
F 224	7:00 AM]. Review of #1] did not administer [3 additional residents [Nurse #1 's] assignment [Nurse #1] signer eMAR that were still i that nurse falsely doc of these medications." A phone interview wa on 10/10/17 at 11:00 provide any information. An initial interview wa on 10/10/17 at 11:30 worked at the facility been in her role as the half. The grievance of the incident on 10/2/1 had not received his ereviewed with the DO was first identified du 10/3/17 when it was mentioned to staff the medications the previassignments were revoluted writing grieversidents, reviewing exported their medical she stated an investignic luded writing grieversidents, reviewing exported their medical she stated an investignic luded writing grieversidents, reviewing exported their medical she stated an investignic luded writing grieversidents, reviewing exported their medical she stated an investignic luded writing grieversidents, reviewing exported their medical she stated an investignic luded writing grieversidents, reviewing exported their medical she stated an investignic luding interviews were larged and including interviews were larged including interv	eMAR reveals that [Nurse recheduled medications for sell. Further investigation of ment of residents indicates doff multiple medications in medication card, indicating tumented the administration of the conducted with Nurse #1 and and the conducted with the DON and the conducted with the conducted the conducted with the reported here evening medications was and the conducted and the conducted the conducted that and the conducted that and the conducted that and the conducted that and conducted the conducted that and conduct		224				
	An initial interview was on 10/10/17 at 11:30 worked at the facility been in her role as the half. The grievance of the incident on 10/2/1 had not received his reviewed with the DO was first identified du 10/3/17 when it was rementioned to staff the medications the previassignments were revolved their medications the previational worked reported their medications the previous stated an investignic ludded writing griev residents, reviewing each to time. She explained including interviews were sidents, it was deteoriented residents all	on during the interview. Its conducted with the DON AM. She reported she has for several months, but had the DON for a month and a too Resident #13 related to too 7 in which he reported he the evening medications was the N. She stated this issue the morning meeting on the too of residents the morning meeting on the too of residents the hours and it was identified to with the residents who tions had not been received. The too of the too of the too tions had not been received. The too of the too of the too of the too too of the too of the too of the too too of the too of the too of the too too of the too of the too of the too too of the too of the too too of the too too of the too of the too too too of the too too too of the too						

I'v '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG	()	(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 10/11/2017	
	ROVIDER OR SUPPLIER DHEALTH & REHABILITA	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CC 2702 FARRELL ROAD SANFORD, NC 27330	DDE	·	
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F 224	had a controlled med the eMAR as adminis off on the narcotic co in the medication car investigation found at diversion by Nurse # review her investigation information. An interview was con 10/10/17 at 1:45 PM. information in the grid incident on 10/2/17 in his evening medication who was assigned to #1. He indicated he not receiving the medications. A second interview won 10/10/17 at 4:03 Freviewed her investig there was no evidence #1 related to any con reported non-controll maintained on medications. She stated the for any of these non-DON explained that for medications were take and/or if they were as when they were signer evealed that based of statements from Resalert and oriented resalert and oriented resalert.	egnitively impaired resident ication that was signed off in stered, but it was not signed introl sheet and it remained it. The DON was asked if the my evidence of drug it. She stated she had to on to provide additional in the evance related to the in which he had not received in the introlled it. He is which he had not received in the introlled it. He is which he had not received in the introlled it. He is which he had not received in the introlled it. He is which he had not received in the introlled it. He is which he had not received in the introlled it. He is which he had not received in the introlled it. He is which he had not received in the introlled it was determined in the introlled it was determined in the introlled introl	F2	224			

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SANFORD HEALTH & REHABILITATION CO			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330				
(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 C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATI	(X5) COMPLETION DATE	
F 224	Assistant (PA) on 10/stated her expectation administered as order aware of the medicate administered as order negative effects to the A follow up interview DON on 10/11/17 at following the investign of the information and any harm to the reside the interviewed Nurses that during the interviewed Nurses signed out medicationally admitted feeding as administered the additionally admitted feeding as administed tube feeding. The Douglected her resident medications and/or to administering them. This interview with the stated that since Nurwere no further issue interviewed a few fan no additional concern three days following investigation she obsection (7:00 PM to 7:00 AM Nurse #3) to ensure administered timely a indicated there were DON reported there were	aducted with the Physician's 10/17 at 4:35 PM. She in was for medications to be streed. She stated she was ions that were not streed and she reported note residents. was conducted with the 10:12 AM. She stated that ation, the PA was informed in the she had no concerns of lents. The DON indicated five Whurse #1 acknowledged cations in the eMAR and had medications. She to documenting a tube red without administering the eVON revealed Nurse #1 had into the sy signing out the she was terminated there are reported. She stated she inlies to ensure there were ins. She stated for two to the completion of the served two of the second shift in nurses (Nurse #2 and	F2	224			

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 10/11/2017	
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT	ATION CO		STREET ADDRESS, CITY, STATE, ZI 2702 FARRELL ROAD SANFORD, NC 27330	P CODE	101112011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		ACTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE	
F 224	Continued From pag issue was caused by terminated the issue 2. Resident #2 was in on 6/30/15 and most 12/27/16 with multipl chronic obstructive phyperlipidemia, hype The quarterly Minimultiple assessment dated 9/3 sognition was fully scheduled pain medical administered antipsy antianxiety medication medication on 7 of 7 back period. A grievance form was for an incident that on narrative of the griev [medications] last nigroom". The corrective the grievance indicated	e 11 Nurse #1 and since she was had been resolved. nitially admitted to the facility recently readmitted on e diagnoses that included ulmonary disease (COPD), rtension, and insomnia. Im Data Set (MDS) 7/17 indicated Resident #2 ' intact. He received cations. Resident #2 was					
	place on 10/2/17 indi medications were Tra medication), Atorvas medication), Clonaze medication), Colace Gabapentin (nerve p A 24-hour initial repo facility Administrator	azodone (antidepressant tatin (high cholesterol					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER D HEALTH & REHABILIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	l	10/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 224	neglect. The report occurred on 10/2/17 times of 7:00 PM and description read, "Refresident that [Nurse offer medications du listed on the report at An Employee Counsindicated Nurse #1 marrative of this notic to administer resider medications as giver still in the medication administer tube feed. The 5-working day read AIT on 10/6/17. The neglect referred to incompleted on 10/3/1 investigation was con 10/3/17 and Nurse #1 The narrative of the indicated an initial gresident that Nurse #1 medications during from 7:00 PM to 7:00 revealed 4 alert and Resident #2) complehad not received any medications during the PM to 7:00 AM. A refunction of the indicated and received any medications to 4 alert and medicationally revealed multiple medications	indicated the incident through 10/3/17 between the d 7:00 AM. The allegation eceived complaints from #1] did not administer nor ring shift". Nurse #1 was is the accused individual. eling Notice dated 10/3/17 met with the DON. The received completed Nurse #1 failed outs' medications, signed out in when the medication was in card, and failed to ing as ordered. eport was completed by the allegation of resident in the 24-hour initial report 7 was substantiated. The impleted by the DON on 1 was terminated on 10/3/17. Investigation of neglect itevance was received by a put failed to administer or offer iter scheduled shift of 10/2/17 to AM. The investigation oriented residents (including the shift of 10/2/17 from 7:00 eview of the eMARs revealed ministered scheduled the shift of 10/2/17 from 7:00 eview of the eMARs revealed ministered scheduled that and oriented residents #2). The investigation Nurse #1, "signed off in eMAR that were still in icating that [Nurse #1] falsely	F 2	24		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SU COMPLE	
		345534	B. WING_			C 10/11	/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	<u> </u> F	10/11	12011
				2702 FARRELL ROAD	_		
SANFORE	HEALTH & REHABILITA	ATION CO		SANFORD, NC 27330			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	-	(X5) COMPLETION DATE
F 224	on 10/10/17 at 11:00 provide any information on 10/10/17 at 11:30 worked at the facility been in her role as the half. The grievance fincident on 10/2/17 in not received his even reviewed with the DO was first identified du 10/3/17 when it was mentioned to staff the medications the previassignments were reviated their medications the previassignments were reviated their medications the previational worked reported their medications were reviewed writing griev residents, reviewing e24-hour report. The linitial review several as administered 5 to time. She explained including interviews we residents, it was deteoriented residents all their evening medications also verified that 1 countries and a controlled medication and the sevening medications are several as a controlled medication and a controlled medication and the several and their evening medications are several as a controlled medication and a controlled medication and the several	as conducted with Nurse #1 AM. Nurse #1 declined to on during the interview. As conducted with the DON AM. She reported she has for several months, but had e DON for a month and a or Resident #2 related to the which he reported he had ing medications was N. She stated this issue ring the morning meeting on noted a couple of residents ey had not received their ious night. The nursing wiewed and it was identified with the residents who tions had not been received. gation was initiated that ances, interviewing eMARs, and completing a DON reported that on the medications were identified 6 hours after their scheduled that upon further review,	F2				
	off on the narcotic colin the medication carl investigation found an	ntrol sheet and it remained t. The DON was asked if the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER DHEALTH & REHABILIT	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	10/11/2017
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F 224	information. An interview was cor 10/10/17 at 1:55 PM information in the gri incident on 10/2/17 in his evening medicati as Nurse #1. He indi effects from not rece Resident #2 reported receiving his medication as medication as medicated to any cor reported her investigned there was no evidence was no	ion to provide additional Inducted with Resident #2 on I. Resident #2 confirmed the evance related to the In which he had not received ons. He identified the nurse cated he had no negative iving the medications. If no further concerns with tions. In our there concerns with tions. In our there is a conducted with the DON In the stated she gation and it was determined the of drug diversion by Nurse introlled medications. She led medications were that in the medication are was no count maintained from these non-controlled in the provided medication cand diversion the me	F 22	,	
	Assistant (PA) on 10 stated her expectation administered as order aware of the medicar	nducted with the Physician's /10/17 at 4:35 PM. She on was for medications to be ered. She stated she was tions that were not ered and she reported no			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345534		, ,	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345534	45534 B. WING		C 10/11/2017		
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT	1.111		STREET ADDRESS, CITY, STATE, ZIP COI 2702 FARRELL ROAD SANFORD, NC 27330		10/11/2017	
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F 224	DON on 10/11/17 at following the investig of the information and any harm to the reside she interviewed Nurse that during the interviewed she signed out medinot administered the additionally admitted feeding as administer tube feeding. The Eneglected her reside medications and/or the administering them. This interview with the stated that since Nurwere no further issue interviewed a few far no additional concent three days following investigation she observed (7:00 PM to 7:00 AM Nurse #3) to ensure administered timely sindicated there were DON reported there related to this issue, issue was caused by terminated the issue 3. Resident #14 was 9/21/17 with multiple	was conducted with the 10:12 AM. She stated that pation, the PA was informed d she had no concerns of dents. The DON indicated se #1 on 10/3/17. She stated iew Nurse #1 acknowledged cations in the eMAR and had medications. She to documenting a tube fred without administering the DON revealed Nurse #1 had not by signing out to be feedings and not were estated she milies to ensure there were estated she milies to ensure there were ens. She stated for two to the completion of the served two of the second shift of nurses (Nurse #2 and medications were and as documented. She no issues observed. The was no ongoing monitoring She stated she believed the Nurse #1 and since she was had been resolved. admitted to the facility on diagnoses that included nic pain, hyperlipidemia,	F 2	24			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION NG		(X3) DATE S COMPL	
		345534	B. WING _			C 10/1	; 1/2017
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CO 2702 FARRELL ROAD SANFORD, NC 27330)DE		
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F 224	#14 's cognition was scheduled pain media medications. Reside antidepressant medic the MDS look back p A grievance form was for an incident that or narrative of the grievastating he did not recenight and did not recenight before". The coresolve the grievance filed, 5-day report was terminated. A review of Resident place on 10/3/17 indimedications were Gamedication, Bisacod (dietary supplement of Trazodone (antideprediction Metoprolol (beta-blook A 24-hour initial report actions). The allegation/incideneglect. The report in occurred on 10/2/17 times of 7:00 PM and description read, "Reresident that [Nurse # offer medications dur listed on the report as	num Data Set (MDS) 28/17 indicated Resident fully intact. He received cations and as needed pain int #14 was administered cation on 7 of 7 days during eriod. Secompleted by Resident #14 courred on 10/3/17. The cance read, "[Resident #14] eive his medication one cive them until 2:30 AM the corrective action by facility to exindicated a 24-report was se filed, and the nurse was #14's physician's orders in cated his evening bapentin (nerve pain y) (laxative), Melatonin utilized as sleep aid), essant medication), and ker). It was completed by the in Training (AIT) on 10/3/17. In type was listed as resident	F2	224			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE COMPI	
		345534	B. WING _			10/) 11/2017
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	1 .0/	
OANEODE	LIEALTH O DELLABILIT	TION 00		2702 FARRELL ROAD			
SANFORL	HEALTH & REHABILITA	ATION CO		SANFORD, NC 27330			
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F 224	Continued From page	e 17	F 2	224			
F 224	indicated Nurse #1 m narrative of this notice to administer residen medications as given still in the medication administer tube feedi. The 5-working day re AIT on 10/6/17. The neglect referred to in completed on 10/3/17 investigation was cor 10/3/17 and Nurse #1 The narrative of the inidicated an initial gri resident that Nurse #1 medications during he from 7:00 PM to 7:00 revealed 4 alert and on Resident #14) complehad not received any medications during the PM to 7:00 AM. A re Nurse #1 had not admedications to 4 aler (including Resident #1 additionally revealed multiple medications medications medications ard, indicated in the revealed multiple medications medications ". A phone interview was on 10/10/17 at 11:00 provide any information and the resident was a phone interview was on 10/10/17 at 11:00 provide any information.	tet with the DON. The e indicated Nurse #1 failed ts' medications, signed out when the medication was card, and failed to mg as ordered. port was completed by the allegation of resident the 24-hour initial report was substantiated. The mpleted by the DON on was terminated on 10/3/17. Investigation of neglect evance was received by a 1 failed to administer or offer er scheduled shift of 10/2/17 AM. The investigation or incited residents (including eted grievances stating they of their scheduled es shift of 10/2/17 from 7:00 view of the eMARs revealed ministered scheduled and oriented residents 14). The investigation Nurse #1, "signed off in eMAR that were still in cating that [Nurse #1] falsely inistration of these	F 2	224			
	on 10/10/17 at 11:30	as conducted with the DON AM. She reported she has for several months, but had					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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		345534	B. WING _			10/11/2017
	ROVIDER OR SUPPLIER HEALTH & REHABIL	ITATION CO		STREET ADDRESS, CITY, STATE, ZIP (2702 FARRELL ROAD SANFORD, NC 27330	CODE	
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F 224	half. The grievance the incident on 10/2 had not received his reviewed with the E was first identified of 10/3/17 when it was mentioned to staff the medications the presidents were. Nurse #1 had work reported their medi. She stated an investinct of the included writing grieresidents, reviewing 24-hour report. The initial review several as administered 5 to time. She explained including interviews residents, it was desoriented residents at their evening medical also verified that 1 had a controlled medication of the medication of in the medication of investigation found diversion by Nurse review her investigation found diversion by Nurse review her investigation found diversion in the gincident on 10/3/17 at 2:10 Pl information in the gincident on 10/3/17	the DON for a month and a e for Resident #14 related to 2/17 in which he reported he is evening medications was DON. She stated this issue during the morning meeting on is noted a couple of residents they had not received their evious night. The nursing reviewed and it was identified ed with the residents who cations had not been received. Interviewing gemarks, and completing a epon reported that on the all medications were identified to 6 hours after their scheduled and that upon further review, is with alert and oriented extermined a total of 4 alert and call stated they had not received extermined a total of 4 alert and extermined a total of 5 alert and extermined a total of 6 alert and extermined a total of 6 alert and extermined a total of 7 alert and extermined a total of 8 alert and extermined a total of 9 alert and extermined a total of 9 alert and extermined a total of 9 alert and extermined a total of 4 alert and extermined a total of	F	224		

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		345534	B. WING			C 10/11/2017
	ROVIDER OR SUPPLIER D HEALTH & REHABILI			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	I	10/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 224	late. He identified the him as Nurse #1. He negative effects related #14 reported no furthis medications. A second interview on 10/10/17 at 4:03 reviewed her investife there was no evidented #1 related to any coreported non-contromaintained on medicarts. She stated the for any of these non DON explained that medications it was in medications were tall and/or if they were awhen they were sign revealed that based statements from Relatert and oriented related hurse #1 signed off residents and had not an interview was concepted as ord aware of the medical administered as ord negative effects to the second size of the medical administered as ord negative effects to the second size of the medical administered as ord negative effects to the second size of the medical administered as ord negative effects to the second size of the medical administered as ord negative effects to the second size of the second size of the medical administered as ord negative effects to the second size of the secon	he nurse who was assigned to e indicated there were no sted to this issue. Resident her concerns with receiving was conducted with the DON PM. She stated she gation and it was determined uce of drug diversion by Nurse introlled medications. She liled medications were cation cards in the medication ere was no count maintained controlled medications. The for these non-controlled impossible to be certain if the ken from the medication card administered the residents in the corroborating sident #14 and 3 additional esidents it was suspected on the medications for these of administered them. Inducted with the Physician 's poly10/17 at 4:35 PM. She on was for medications to be ered. She stated she was attions that were not ered and she reported no me residents.	F 2	,		
	DON on 10/11/17 at following the investion of the information ar	was conducted with the 10:12 AM. She stated that gation, the PA was informed and she had no concerns of dents. The DON indicated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345534	B. WING		C 10/11/2017	
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT	TATION CO	2	TREET ADDRESS, CITY, STATE, ZIP CODE 702 FARRELL ROAD SANFORD, NC 27330	10/11/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 224	that during the intervishe signed out medinot administered the additionally admitted feeding as administer tube feeding. The Ineglected her reside medications and/or tadministering them. This interview with the stated that since Nurver no further issue interviewed a few fair no additional concert three days following investigation she observed the stated that since Nurver administered timely indicated there were DON reported there related to this issue, issue was caused by terminated the issue was caused by terminated the issue was caused by terminated the issue with multiple diagnost hypertension, atrial of the hyperlipidemia. The 30-day Minimum assessment dated 8 #15's cognition was scheduled pain medicated the significant of the support of t	se #1 on 10/3/17. She stated riew Nurse #1 acknowledged cations in the eMAR and had a medications. She It to documenting a tube ered without administering the DON revealed Nurse #1 had ents by signing out tube feedings and not. The DON continued. She rise #1 was terminated there ere reported. She stated she milies to ensure there were ens. She stated for two to the completion of the served two of the second shift in urses (Nurse #2 and medications were and as documented. She in o issues observed. The was no ongoing monitoring She stated she believed the roll in the property was a had been resolved. The damitted to the facility on cently readmitted on 7/13/17 sees that included fibrillation, depression, and	F 224			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345534	B. WING		C 10/11/2017
	ROVIDER OR SUPPLIER HEALTH & REHABILI	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	10/11/2011
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F 224	Continued From page	ge 21	F 224	4	
		cation on 7 of 7 days during period. She received diuretic 7 days.			
	for an incident that a narrative of the grie stated she had not night and another n late. The corrective the grievance indicated in terminated. A review of Resider place on 10/2/17 incident in the corrective that the grievance indicates the grievance indicates the grievance in	as completed by Resident #15 coccurred on 10/2/17. The vance indicated Resident #15 received her medications one ight she received them really action by facility to resolve ated a 24-report was filed, ed, and the nurse was at #15's physician's orders in dicated his evening razodone (antidepressant statin (high cholesterol			
	(beta-blocker), and	(acetaminophen), Metoprolol Eliquis (anticoagulant).			
	facility Administrato The allegation/incid neglect. The report occurred on 10/2/17 times of 7:00 PM ar description read, "R resident that [Nurse offer medications du	ort was completed by the r in Training (AIT) on 10/3/17. ent type was listed as resident indicated the incident r through 10/3/17 between the nd 7:00 AM. The allegation electived complaints from #1] did not administer nor uring shift". Nurse #1 was as the accused individual.			
	indicated Nurse #1 narrative of this noti to administer reside medications as give	seling Notice dated 10/3/17 met with the DON. The ice indicated Nurse #1 failed ints' medications, signed out in when the medication was in card, and failed to ding as ordered.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345534	B. WING		C 10/11/2017		
	ROVIDER OR SUPPLIER HEALTH & REHABIL	TATION CO	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	10/11/2011		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION		
F 224	Continued From pa		F 224				
	AIT on 10/6/17. The neglect referred to a completed on 10/3/investigation was on 10/3/17 and Nurse. The narrative of the indicated an initial gresident that Nurse medications during from 7:00 PM to 7:00 revealed 4 alert and Resident #15) completed that the negligible of the received armedications during PM to 7:00 AM. A Nurse #1 had not a medications to 4 ale (including Resident additionally reveale multiple medication card, including complete the redication card, including complete the reference of the reference to the reference of the referen	report was completed by the e allegation of resident in the 24-hour initial report 17 was substantiated. The empleted by the DON on #1 was terminated on 10/3/17. Investigation of neglect grievance was received by a #1 failed to administer or offer her scheduled shift of 10/2/17 to AM. The investigation of oriented residents (including poleted grievances stating they by of their scheduled the shift of 10/2/17 from 7:00 review of the eMARs revealed dministered scheduled ert and oriented residents #15). The investigation of Nurse #1, "signed off in eMAR that were still in dicating that [Nurse #1] falsely ministration of these					
	on 10/10/17 at 11:0 provide any informal An initial interview on 10/10/17 at 11:3 worked at the facilit been in her role as half. The grievance the incident on 10/2 had not received his reviewed with the E	vas conducted with Nurse #1 0 AM. Nurse #1 declined to ation during the interview. vas conducted with the DON 0 AM. She reported she has y for several months, but had the DON for a month and a e for Resident #15 related to 2/17 in which he reported he is evening medications was in ON. She stated this issue during the morning meeting on					

			(X3) DATE COMP	SURVEY			
			A. BOILD			، ا	С
		345534	B. WING				11/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	,	
SANFORE	HEALTH & REHABILI	FATION CO		2	702 FARRELL ROAD		
SANI OKL	TILALITI & KLIIADILI	IATION CO		8	SANFORD, NC 27330		
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F 224	mentioned to staff the medications the prevassignments were reassignments were reassignments were reassignments were reassignments were reassignments were reassignments were reported their medical She stated an invessincluded writing grie residents, reviewing 24-hour report. The initial review several as administered 5 to time. She explained including interviews residents, it was detoriented residents at their evening medicalso verified that 1 chad a controlled methe eMAR as adminoff on the narcotic continuestigation found a diversion by Nurse review her investigatinformation. A second interview word on 10/10/17 at 4:03 reviewed her investit there was no evident #1 related to any coreported non-control maintained on medical reported reassignments.	noted a couple of residents bey had not received their vious night. The nursing eviewed and it was identified and with the residents who ations had not been received. Itigation was initiated that vances, interviewing eMARs, and completing a DON reported that on the medications were identified to 6 hours after their scheduled that upon further review, with alert and oriented ermined a total of 4 alert and all stated they had not received ations from Nurse #1. It was ognitively impaired resident dication that was signed off in istered, but it was not signed ontrol sheet and it remained att. The DON was asked if the any evidence of drug et 1. She stated she had to tion to provide additional was conducted with the DON PM. She stated she gation and it was determined are of drug diversion by Nurse introlled medications. She alled medications were cation cards in the medication	F	224			
	carts. She stated th for any of these non DON explained that medications it was in	cation cards in the medication ere was no count maintained -controlled medications. The for these non-controlled mpossible to be certain if the ken from the medication card					

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 PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO		•	270	REET ADDRESS, CITY, STATE, ZIP CODE 02 FARRELL ROAD NNFORD, NC 27330		
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F 224	when they were signer evealed that based of statements from Resident and oriented residents and had not an interview was con Assistant (PA) on 10/stated her expectation administered as order aware of the medicat administered as order aware effects to the An interview was con 10/11/17 at 8:00 AM. Information in the grid incident on 10/2/17 in her evening medication in the grid incident on 10/2/17 in her evening medication in the grid incident on 10/2/17 in her evening medication in the grid incident on 10/2/17 in her evening medication in the grid incident on 10/2/17 in her evening medication in the grid incident on 10/2/17 in her evening medication in the grid incident on 10/2/17 in her evening medication in the grid incident on 10/11/17 at 10/11/17 in the grid incident on 10/11/17 at 10/11/17 in the grid incident incident incidents. A follow up interview DON on 10/11/17 at 10/11/11/17 in the information and any harm to the resid she interviewed Nurst that during the interviewed Nurst that during the interviewed incidents administered the additionally admitted	dministered the residents and out by Nurse #1. She on the corroborating ident #15 and 3 additional didents it was suspected on the medications for these it administered them. ducted with the Physician's 10/17 at 4:35 PM. She in was for medications to be red. She stated she was ions that were not red and she reported note residents. ducted with Resident #15 on Resident #15 confirmed the evance related to the in which she had not received ons one night and another er medications several hours in enurse who was assigned the indicated there were noted to this issue. Resident er concerns with receiving was conducted with the 10:12 AM. She stated that ation, the PA was informed if she had no concerns of ents. The DON indicated er #1 on 10/3/17. She stated ew Nurse #1 acknowledged thations in the eMAR and had	F	224			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
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F 224	24 Continued From page 25		F 2	224				
	tube feeding. The Displayment in the Interest of the Interest	OON revealed Nurse #1 had						
	stated that since Nur were no further issue interviewed a few far no additional concert three days following investigation she obs (7:00 PM to 7:00 AM Nurse #3) to ensure administered timely a indicated there were DON reported there related to this issue.	and as documented. She no issues observed. The was no ongoing monitoring She stated she believed the Nurse #1 and since she was						
	10/16/14 with multipl neuropathy, insomni hyperlipidemia. The annual Minimum assessment dated 9, #16's cognition was received scheduled p	•						
	and antianxiety medithe MDS look back p A review of Resident place on 10/2/17 ind	ication on 7 of 7 days during period. #16's physician's orders in icatedhis evening onazepam (antianxiety						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 224	medication), Neuror and Divalproex Sodinal Divalpro	statin (high cholesterol of the chin (nerve pain medication), for the chin (mood stabilizer). For the chin Training (AIT) on 10/3/17. For the chin Training (AIT) on 10/3/17. For the chin th	F 224	,	
	AIT on 10/6/17. The neglect referred to in completed on 10/3/1 investigation was con 10/3/17 and Nurse # The narrative of the indicated an initial gresident that Nurse # medications during from 7:00 PM to 7:0 revealed 4 alert and grievances stating the their scheduled medications during the scheduled medications during the from 7:00 PM to 7:0 revealed 4 alert and grievances stating the first scheduled medications during the first scheduled medications are scheduled medications.	eport was completed by the e allegation of resident in the 24-hour initial report in the impleted by the DON on investigation of neglect revence was received by a set in the investigation of initial initi			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 224	administered scheduland oriented residen additionally revealed multiple medications medication card, indidocumented the adminedications". A phone interview woon 10/10/17 at 11:00 provide any informat. An initial interview woon 10/10/17 at 11:30 worked at the facility been in her role as the half. The Employee #1 dated 10/3/17 was She stated this issue the morning meeting noted a couple of residuely had not receive previous night. The reviewed and it was worked with the residuely medications had not an investigation was grievances, interview eMARs, and comple DON reported that of medications were ide 6 hours after their so that upon further revalert and oriented residual of 4 alert and or they had not receive from Nurse #1. It was cognitively impaired	as conducted with Nurse #1 AM. Nurse #1 declined to ion during the interview. as conducted with the DON AM. She reported she has for several months, but had ne DON for a month and a Counseling Notice for Nurse reviewed with the DON. awas first identified during on 10/3/17 when it was sidents mentioned to staff d their medications the nursing assignments were identified Nurse #1 had dents who reported their been received. She stated initiated that included writing ving residents, reviewing ting a 24-hour report. The n the initial review several entified as administered 5 to heduled time. She explained iew, including interviews with sidents, it was determined a riented residents all stated d their evening medications	F2	224		

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F 224	signed off in the eMA was not signed off on and it remained in the was asked if the inve of drug diversion by had to review her invadditional information. A second interview won 10/10/17 at 4:03 Freviewed her investig there was no evidence #1 related to any con reported non-controllemaintained on medicates. She stated the for any of these non-DON explained that freedications it was immedications were taken and/or if they were accombined that based of statements from 4 ale and the evidence from control sheet, it was soff on the medication had not administered. An interview was con Assistant (PA) on 10/10/10/10/10/10/10/10/10/10/10/10/10/1	R as administered, but it the narcotic control sheet emedication cart. The DON stigation found any evidence Nurse #1. She stated she estigation to provide h. as conducted with the DON PM. She stated she ation and it was determined at en of drug diversion by Nurse strolled medications. She end medications were ation cards in the medication are was no count maintained controlled medications. The for these non-controlled apossible to be certain if the en from the medication card diministered the residents end out by Nurse #1. She on the corroborating ent and oriented residents in Resident #16's narcotic suspected Nurse #1 signed as for these residents and them. ducted with the Physician's 10/17 at 4:35 PM. She in was for medications to be red. She stated she was ions that were not red and she reported no	F 2	224			

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F 224	of the information an any harm to the reside she interviewed Nurse that during the interviewed she signed out medinot administered the additionally admitted feeding as administer tube feeding. The Eneglected her reside medications and/or tradministering them. This interview with the stated that since Nurwere no further issue interviewed a few fair no additional concent three days following investigation she observed there administered timely administered timely administered there were DON reported there related to this issue, issue was caused by terminated the issue. 6. Resident #17 was 4/5/16 and most recovered with multiple diagnosis and schizophrenia. The quarterly Minimal 9/13/17 indicated Resident #18	gation, the PA was informed and she had no concerns of dents. The DON indicated se #1 on 10/3/17. She stated riew Nurse #1 acknowledged cations in the eMAR and had medications. She I to documenting a tube ered without administering the DON revealed Nurse #1 had into the book revealed Nurse #1 had into the properties of the series and not when the properties of the series reported. She stated she milies to ensure there were the served two of the served. The was no ongoing monitoring she stated she believed the roll of the was no ongoing monitoring. She stated she believed the roll of the served the resolved. The was no ongoing monitoring she stated she believed the roll of the served the resolved. The was no ongoing monitoring she stated she believed the roll of the served the resolved.	F 2	24			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 224	antipsychotic medical medication 7 of 7 day period. He received 7 days and antianxie: Resident #17 receive nutrition from tube feed 4 physician's order d #17 indicated Isosour feeding formula) at 6 continuous via gastro daily for supplement. A nutritional progress indicated Resident #10 mouth) and he was feeding. A written statement we Manager for an incide Resident #17 on 10/2 statement read, "On [Resident #17 's root entering the room [Reup to any tube feedin tubing was not connected Nurse #1 mouth and the medications as given still in the medication administer tube feedin A phone interview was on 10/10/17 at 11:00	ant #17 was administered tion and antidepressant of during the MDS look back antibiotic medication on 5 of the medication on 1 of 7 days. It is defined to the first set of the medication on 1 of 7 days. It is defined to the first set of the medication on 1 of 7 days. It is defined to the first set of the medication on 1 of 7 days. It is defined to the first set of the medication on 1 of 7 days. It is defined to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card, and failed to the first set of the medication was card.	F2	224			

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F 224	Assistant (PA) on 10. stated her expectation be administered as or aware of the tube feet administered as order negative effects to the An interview was conto/11/17 at 10:12 AN Notice for Nurse #1 with the DON. The Dinterviewed Nurse #1 during the interview of the documenting a tube without actually administered the merevealed Nurse #1 has signing out tube feed not administering the This interview with the stated that since Nurwere no further issue interviewed a few far no additional concern three days following observed two of the stated that since of the stated t	aducted with the Physician's (10/17 at 4:35 PM. She on was for tube feedings to ordered. She stated she was eding that was not ered and she reported note resident. Inducted with the DON on of the Employee Counseling dated 10/3/17 was reviewed DON indicated she on 10/3/17. She stated that Nurse #1 admitted to feeding as administered inistering the tube feeding. Inowledged she signed out MAR and then had not dications. The DON and neglected her residents by lings and/or medications and im as ordered. The DON continued. She is the provided she stated she in the serior of the incident she is second shift (7:00 PM to 7:00).	F 2				
	tube feedings and mitimely and as docum were no issues obsethere was no ongoing						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 224	Continued From pag	ge 32	F 224		
F 322 SS=D	Manager on 10/11/1 the written statement Resident #17 not be feeding as ordered of typically came into we believed she was not the floor nurse short reported the tube feed was not connected to indicated Nurse #1 fr Resident #17 the pre Manager stated she Resident #17 had not She reported she ho Resident #17, she in informed the physici NG TREATMENT/SI EATING SKILLS CFR(s): 483.25(g)(4) (g) Assisted nutrition (Includes naso-gaste both percutaneous expercutaneous endos enteral fluids). Base comprehensive asse ensure that a reside (4) A resident who halone or with assistat methods unless the demonstrates that e indicated and conse (5) A resident who is	ERVICES - RESTORE)(5) n and hydration. ric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's essment, the facility must	F 322		11/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/11/2017	
			:	2702 FARRELL ROAD		
SANFORE) HEALTH & REHABILITA	ATION CO	,	SANFORD, NC 27330		
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F 322	Continued From page 33		F 322			
F 322	to restore, if possible, prevent complications but not limited to aspi vomiting, dehydration and nasal-pharyngea This REQUIREMENT by: Based on record revi interview, and Physic the facility failed to prordered to 1 of 4 resid feeding (Resident #17 Resident #17 was add 4/5/16 and most rece with multiple diagnost and schizophrenia. The plan of care for For Problem/Need area of Gastrostomy (PEG) to and hydration initiated. The quarterly Minimu 9/13/17 indicated Resident #17 indicated Resident #17 received a 7 days and antianxiet Resident #17 receive nutrition from tube feed a physician's order da #17 indicated Isosour feeding formula) at 68 days and antianxiet Resident #17 receivenutrition from tube feed a physician's order da #17 indicated Isosour feeding formula) at 68 days and antianxiet Resident #17 receivenutrition from tube feeding formula) at 68 days and antianxiet Resident #17 receivenutrition from tube feeding formula) at 68 days and antianxiet Resident #17 indicated Isosour feeding formula) at 68 days and antianxiet Resident #17 indicated Isosour feeding formula) at 68 days and antianxiet Resident #17 indicated Isosour feeding formula) at 68 days and antianxiet Resident #17 indicated Isosour feeding formula) at 68 days and antianxiet Resident #17 indicated Isosour feeding formula) at 68 days and antianxiet Resident #17 indicated Isosour feeding formula) at 68 days and antianxiet Resident #17 indicated Isosour feeding formula) at 68 days and antianxiet Resident #17 indicated Isosour feeding formula) at 68 days and antianxiet Resident #17 indicated Isosour feeding formula) at 68 days and antianxiet Resident #17 indicated Isosour feeding formula) at 68 days and antianxiet Resident #17 indicated Isosour feeding formula) at 68 days and antianxiet Resident #17 indicated Isosour feeding formula)	oral eating skills and to of enteral feeding including ration pneumonia, diarrhea, metabolic abnormalities, lulcers. Is not met as evidenced ew, resident interview, staff ian 's Assistant interview, ovide tube feeding as dents reviewed for tube 7). The findings included: mitted to the facility on intly readmitted on 9/1/17 es that included Parkinson's estate included Parkinson's estate included Parkinson's entered and in 7/18/17. In Data Set (MDS) dated in a sident #17's cognition was enceived scheduled pain in the #17 was administered in and antidepressant is during the MDS look back antibiotic medication on 5 of and y medication on 1 of 7 days. In a side of 13/17 for Resident in the modern of the side of 1.5 (nutritional tube in milliliters (ml)/hour (hr)	F 322	F322 – Preparation and or execution of this plat does not constitute admission or agreement by the Provider of the truth facts alleged or conclusion set forth on statement of deficiencies. The plan is prepared and executed solely because is required by the provisions of State at Federal law. Resident #17 was administered the omitted tube feeding immediately following observation by the oncoming nurse on October 3, 2017. The physicia was notified on October 3, 2017 and no harm was identified by the physician. A 100% audit of all residents receiving tube feedings was completed by Staff Development Coordinator and Administrator-In-Training on October 1 2017 to ensure that residents are receiving correct tube feeding formula administered at correct rate and time was no issues noted. All licensed nursing staff was in-service by the Staff Development Coordinator between the dates of October 15, 2017 and November 6, 2017 on administration.	of the it nd 2, vith ed	
	ordered to 1 of 4 reside feeding (Resident #17 Resident #17 was add 4/5/16 and most recewith multiple diagnost and schizophrenia. The plan of care for For Problem/Need area of Gastrostomy (PEG) to and hydration initiated. The quarterly Minimu 9/13/17 indicated Reseverely impaired. Homedications. Resident antipsychotic medicated medication 7 of 7 day period. He received a 7 days and antianxiet Resident #17 receive nutrition from tube feed. A physician's order da #17 indicated Isosour feeding formula) at 68	dents reviewed for tube 7). The findings included: mitted to the facility on intly readmitted on 9/1/17 es that included Parkinson's desident #17 included the f Percutaneous Endoscopic ube for adequate nutrition d on 7/18/17. In Data Set (MDS) dated sident #17's cognition was e received scheduled pain int #17 was administered ion and antidepressant s during the MDS look back antibiotic medication on 5 of by medication on 1 of 7 days. d 51% or more of his eding. Interest and the second of the second		agreement by the Provider of the truth facts alleged or conclusion set forth on statement of deficiencies. The plan is prepared and executed solely because is required by the provisions of State at Federal law. Resident #17 was administered the omitted tube feeding immediately following observation by the oncoming nurse on October 3, 2017. The physicia was notified on October 3, 2017 and no harm was identified by the physician. A 100% audit of all residents receiving tube feedings was completed by Staff Development Coordinator and Administrator-In-Training on October 1 2017 to ensure that residents are receiving correct tube feeding formula administered at correct rate and time was issues noted. All licensed nursing staff was in-service by the Staff Development Coordinator between the dates of October 15, 2017	the it it ind an c 2, vith ed von	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 322	indicated Resident # by mouth) and he w feeding. A written statement Manager for an incide Resident #17 on 10, statement read, "On [Resident #17 's rocentering the room [Fup to any tube feeditubing was not connumerative of this notion to administer tube feeditubing was not connumerative of this notion administer tube feeditubing was not connumerative of this notion administer tube feeditubing was not connumerative of this notion administer tube feeditubing was not connumerative of this notion administer tube feeditubing was consistent (PA) on 10 stated her expectation be administered as aware of the tube feeditubing was consistent as ord negative effects to Feeditubing was consistent of the state	is note dated 9/13/17 #17's diet was NPO (nothing as ordered continuous tube) was completed by the Unit dent that occurred with (/2/17. The narrative of the 10/2/17 I was called into om] by floor nurse. Upon Resident #17] was not hooked ng. Bag was hanging but nected to the [Resident #17]" seling Notice dated 10/3/17 met with the DON. The ce indicated Nurse #1 failed beding as ordered to Resident ment at the facility was was conducted with Nurse #1 OAM. Nurse #1 declined to tion during the interview. Inducted with the Physician's 10/10/17 at 4:35 PM. She on was for tube feedings to ordered. She stated she was reding that was not ered and she reported no Resident #17. Inducted with the DON on M. The Employee Counseling dated 10/3/17 was reviewed	F 322	any unexpected lapse in tube feed delivery of greater than 60 minutes accurate documentation via nursin notes. Any licensed nurse not in-se by November 6, 2017 will not work in-servicing is completed. In order to provide quality assurant Staff Development Coordinator or designee will audit a minimum of the residents receiving tube feedings of four weeks and longer if indicate ensure administration of proper feeding proper physician orders, including proper notification of provider for any unexplapse in tube feeding delivery of graph than 60 minutes and accurate documentation via nursing notes. For these audits will be presented in Quality Assurance Performance Improvement meeting to determine further monitoring is indicated.	s and g erviced until ce, the wo veekly ed to eding per kpected eater Results the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
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CANEODE	LICALTU O DELIABILIT	ATION CO		2702 FARRELL ROAD			
SANFURL	HEALTH & REHABILIT	ATION CO		SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 322	Continued From page 35 during the interview Nurse #1 admitted to		F3	322			
	documenting a tube without actually adm She stated that since there were no further she interviewed a few were no additional or to three days following she observed two of 7:00 AM) nurses (Nursure tube feedings ordered. She indicated observed. The DON ongoing monitoring matted she believed to Nurse #1 and since shad been resolved.	feeding as administered inistering the tube feeding. e Nurse #1 was terminated rissues reported. She stated w families to ensure there oncerns. She stated for two ng the report of the incident the second shift (7:00 PM to urse #2 and Nurse #3) to swere administered as ted there were no issues reported there was no elated to this issue. She the issue was caused by she was terminated the issue					
E 441	Manager on 10/11/11 the written statement Resident #17 not bei feeding as ordered of typically came into w believed she was not the floor nurse shortly reported the tube feed was not connected to indicated Nurse #1 h Resident #17 the pref Manager stated she Resident #17 had not She reported she ho Resident #17, she in informed the physicial	7 at 1:50 PM. She confirmed at she completed about any administered his tube in 10/2/17. She stated she fork around 8:00 AM so she stifled of this information by y after 8:00 AM. She stating bag was hanging, but it to Resident #17. She had been assigned to evious shift. The Unit was unsure how long of received his tube feeding to formed the DON, and she an.	F	141		11/6/17	
F 441 SS=D		OL, PREVENT SPREAD,	F 4	41		11/6/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
		345534	B. WING				C 11/2017
	ROVIDER OR SUPPLIER	ATION CO	· · · · · · · · · · · · · · · · · · ·	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	10,	11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page (a) Infection prevention The facility must estal and control program (all minimum, the follow) (1) A system for prevention prevention of the program of the providing services unarrangement based under the program, which is a system of surveil possible communication of the program, which is a system of surveil possible communication of the program, which is a system of surveil possible communication of the program of	blish an infection prevention (IPCP) that must include, at ving elements: enting, identifying, reporting, ntrolling infections and ses for all residents, staff, and other individuals der a contractual upon the facility assessment to §483.70(e) and following undards (facility assessment asse 2); policies, and procedures h must include, but are not allance designed to identify ble diseases or infections and to other persons in the mossible incidents of se or infections should be		441	DEFICIENCY)		
	(iv) When and how is resident; including bu (A) The type and dura						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED C			
		345534	B. WING		10/11/2017
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT.	ATION CO	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	10/11/2017
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475
F 441	least restrictive possicircumstances. (v) The circumstance must prohibit employ disease or infected s contact with resident contact will transmit to the contact	at the isolation should be the ble for the resident under the sunder which the facility ees with a communicable kin lesions from direct is or their food, if direct the disease; and exprocedures to be followed rect resident contact. In reding incidents identified CP and the corrective facility. It is must handle, store, and in the facility will conduct an PCP and update their ary. In is not met as evidenced item, observation and staff of failed to failed to change and after providing before providing further care	F 441	F441 □ Nursing Assistant #2 was in-serviced to the Staff Development Coordinator on October 10, 2017 regarding infection control, proper incontinence care, and importance of changing gloves between contaminations. All staff, including: licensed nurses, nursides, dietary, housekeeping, and administration were in-serviced by the Staff Development Coordinator between	en

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		345534	B. WING			C 10/11/2017
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP (CODE	10/11/2017
SANFORD	HEALTH & REHABILITA	ATION CO		2702 FARRELL ROAD SANFORD, NC 27330		
(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 ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 441	Continued From page	: 38	F 4	41		
	The policy also indicated gloves, as necessary resident to prevent or body site to another. On 10/10/17 at 1:25 princontinence care water Assistant (NA) #1 and incontinence of stool to place a clean under to touch clean objects bedside rail and call bedside rail	ted that staff "change during the care of a coss-contamination from one ." If an an observation of so done with Nursing In NA #2. NA #2 cleaned and used the same gloves regarment and clothing and in the room such as the cell. If an an interview was In the same should have changed tinence care before starting NA #2 stated that the dother one every day to the touched.		October 15, 2017 and Noveregarding standard precaubut not limited to, changing between clean and dirty suprevention of cross-contart one body site to another of equipment, blood borner and communicable diseas not in-serviced by Novembrot work until in-servicing. All licensed nurses and nureducated by the Staff Deve Coordinator between Octor and November 6, 2017 regincontinence care, includir limited to standard precautof gloves, and hand washing in-serviced by November 6 work until in-servicing is considered in the consumer standard precautors and the presented in the Querformance Improvement.	ations; including of gloves purfaces, mination from recontamination pathogens, es. Any staff per 6, 2017 will is completed. Arse aides were elopment ober 10, 2017 garding proper by but not tions, changing. Any staff per 6, 2017 will not purpose to be a completed. Assurance, the nator or elos surveillance care for surveillance to the sea audit pality Assurant meeting to	e g g not ut
F 514		TE/ACCUDATE/ACCESSID	F 5	determine if additional moi indicated.	intoring is	11/6/17
SS=E	LE CFR(s): 483.70(i)(1)(1)	TE/ACCURATE/ACCESSIB 5)				

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		345534	B. WING		C 10/11/2017		
	ROVIDER OR SUPPLIER D HEALTH & REHABILIT	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 514	Continued From pag	e 39	F 5	14			
	standards and practi	th accepted professional ces, the facility must ords on each resident that					
	(i) Complete;						
	(ii) Accurately docum	nented;					
	(iii) Readily accessib	le; and					
	(iv) Systematically or	ganized					
	(5) The medical reco	ord must contain-					
	(i) Sufficient informat	ion to identify the resident;					
	(ii) A record of the re	sident's assessments;					
	(iii) The comprehens provided;	ive plan of care and services					
	(iv) The results of an and resident review determinations cond						
	(v) Physician's, nurs professional's progre	e's, and other licensed ess notes; and					
	services reports as r This REQUIREMEN by:	ology and other diagnostic equired under §483.50. T is not met as evidenced view, resident interview, and		F514 –			
	staff interview, the fa medication administr	icility failed to have accurate ration records for 6 of 6 The findings included:		The physician was notified of the omit medications for Residents (#13, #2, # #15, #16, and #17) on October 3, 201	14,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	· ,	E SURVEY IPLETED				
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		345534	B. WING _		1 1	0/11/2017				
NAME OF P	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CO						
				2702 FARRELL ROAD						
SANFORE	HEALTH & REHABI	LITATION CO		SANFORD, NC 27330						
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TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TI DEFICIENC		DATE				
F 514	Continued From p	page 40	F 5	514						
				The physician identified tha	t no harm					
	1. Resident #13 w	as admitted to the facility on		occurred in the omission of	medications.					
	8/11/17 with multip	ple diagnoses that included								
	heart disease, Dia	abetes Mellitus Type 2, chronic		Between October 30, 2017	and November					
	pain syndrome, hy	yperlipidemia, and		3, 2017, all residents with a						
	hypernatremia.			equal to or higher than 11 v						
				interviewed by the Director						
		nimum Data Set (MDS)		Staff Development Coordin	•					
		d 8/18/17 indicated Resident		Worker to ensure there wer						
		vas fully intact. He received		instances of neglect including	-					
		edications and as needed pain ident #13 was administered		limited to the omission of m	edication					
		ssant medication, and diuretic		administration.						
		f 7 days during the MDS look		Between October 30, 2017	and November					
		vas administered antianxiety		3, 2017 the Responsible Pa						
		f 7 days during the MDS look		residents with a BIMS score	•					
	back period.	17 days daring the MDO look		were contacted by the Direct						
	Juliu pomou.			Staff Development Coordinate						
	A grievance form	was completed by Resident #13		Unit Manager to ensure the						
		t occurred on 10/2/17. The		additional instances of negl						
	narrative of the gr	ievance read, "I never got my		but not limited to the omissi						
		s] or insulin". The grievance		medication administration.						
	investigation and	findings indicated Resident #13								
	was alert and orie	nted. His electronic Medication		All nursing staff was in-serv	iced by the					
	Administration Re	cord (eMAR) was reviewed and		Staff Development Coordinate	ator between					
	his medications ha	ad been signed out by Nurse		the dates of October 15, 20	17 and	1 ng, se				
	#1. Nurse #1 was	s interviewed by the Director of		November 6, 2017 regardin	g accurate	ng, see g n n to,				
	Nursing (DON) an	nd was terminated.		and timely documentation of						
				administration including but						
		ent #13 's physician 's orders		following physician's order,						
		7 indicated his evening		administration within the tim						
		Lantus (insulin), Humalog		ordered, and signing the Me						
	, , , , , , , , , , , , , , , , , , , ,	in (high cholesterol medication),		Administration Record accu	, ,					
		e pain medication), Tylenol, and		nursing staff not in-serviced	-					
	Sodium chloride.			6, 2017 will not work until in	-servicing is					
	A 24 have initial	apart was completed by the		completed.						
		eport was completed by the		In order to provide suclifica	agurango tha					
		tor in Training (AIT) on 10/3/17. ident type was listed as resident		In order to provide quality a Director of Nursing, Staff De						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345534	B. WING _		10/	11/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP (CODE	
CANEODI	DUEALTH & DEHADI	ITATION CO		2702 FARRELL ROAD		
SANFURI	D HEALTH & REHABII	LITATION CO		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 514	Continued From p	age 41	F 5	514		
F 314	neglect. The repo occurred on 10/2/² times of 7:00 PM a description read, " [Resident #13] that nor offer medicatic listed on the report An Employee Coulindicated Nurse #² narrative of this not to administer resid medications as gives till in the medications as gives till in the medication administer tube feat the following that the feat that the fea	rt indicated the incident 17 through 10/3/17 between the and 7:00 AM. The allegation Received complaints from t [Nurse #1] did not administer ons during shift". Nurse #1 was t as the accused individual. Inseling Notice dated 10/3/17 If met with the DON. The otice indicated Nurse #1 failed lents ' medications, signed out wen when the medication was ion card, and failed to eding as ordered. If report was completed by the the allegation of resident in the 24-hour initial report 18/17 was substantiated. The restigation indicated a review of that Nurse #1 signed off multiple AR that were still in medication at nurse falsely documented the		Coordinator, or Nurse Unit interview a minimum of two a BIMS score equal to or gweekly for four weeks and indicated to ensure no addinstances of neglect, inclumedication administration Findings of these interview presented in the Quality At Performance Improvement determine if results indicate continued monitoring. In order to provide quality Director of Nursing, Staff Et Coordinator, or Nurse Unit observe a minimum of two administration passes week weeks and longer if indicated additional instances of negomission of medication ad have occurred, and the Met Administration Record is caccurate. Findings of these administration observation presented in the Quality At Performance Improvement determine if results indicate continued monitoring.	o residents with greater than 11 longer if ditional ding omission of have occurred. It was will be surance to the aneed for assurance, the Development to Managers will be medication existed to ensure no glect, including ministration edication emplete and emedication is will be surance to Meeting to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUC A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED C				
		345534	B. WING		10/11/2017		
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT	TATION CO	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 514	10/10/17 at 4:03 PM the investigation tha allegation of neglect report dated 10/3/17 investigation reveals medications as giver still in the medication Resident #13 was or eMAR was reviewed DON revealed that be statements from Resident and distinguished Resident and considerable with the statements from Resident and the st	nducted with the DON on She reviewed the results of t was conducted for the referred to in the 24-hour She indicated the d Nurse #1 had signed out n when the medication was n card. She confirmed ne of the residents whose I during the investigation. The based on the corroborating sident #13 was well as 3 priented residents it was	F 514				
	following the investig of the information are any harm to the resistence interviewed Nurse that during the interviewed seems and interviewed administered the additionally admitted feeding as administed tube feeding. This follow up interviewed feeding as administed tube feeding.	gation, the PA was informed and she had no concerns of dents. The DON indicated se #1 on 10/3/17. She stated view Nurse #1 acknowledged cations in the eMAR and had					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION B		COMPLETED	
		345534	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330			
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F 514	Nurse #3) to ensure administered timely indicated there were DON reported there related to this issue issue was caused be terminated the issue. 2. Resident #2 was on 6/30/15 and most 12/27/16 with multipe chronic obstructive hyperlipidemia, hype. The quarterly Minimassessment dated is cognition was fully scheduled pain meadministered antips antianxiety medicate.	M) nurses (Nurse #2 and e medications were and as documented. She e no issues observed. The e was no ongoing monitoring and as the stated she believed the by Nurse #1 and since she was e had been resolved. Initially admitted to the facility st recently readmitted on oble diagnoses that included pulmonary disease (COPD), ertension, and insomnia. Inum Data Set (MDS) 10/7/17 indicated Resident #2 ' y intact. He received dications. Resident #2 was	F 51	4			
	for an incident that narrative of the grie [medications] last n room". The correct the grievance indicated the grievance indicated terminated. A review of Resider place on 10/2/17 in medications were T	razodone (antidepressant					
	medication), Clonaz	statin (high cholesterol zepam (antianxiety e (stool softener/laxative),					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 10/11/2017
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	_ _	10/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COME (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 514	A 24-hour initial report facility Administrator. The allegation/incide neglect. The report occurred on 10/2/17 times of 7:00 PM and description read, "Refersident that [Nurse offer medications du listed on the report at the control of the control of the resident that [Nurse offer medications at the control of the contro	ain medication), and Tylenol. Int was completed by the in Training (AIT) on 10/3/17. Int type was listed as resident indicated the incident through 10/3/17 between the d 7:00 AM. The allegation eceived complaints from #1] did not administer nor ring shift". Nurse #1 was s the accused individual. Intelling Notice dated 10/3/17 intelling N	F	514		
	10/10/17 at 1:55 PM information in the gri	nducted with Resident #2 on . Resident #2 confirmed the evance related to the n which he had not received				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345534	B. WING		C 10/11/2017
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	TATION CO	\$ 2 \$		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 514	as Nurse #1. He ind effects from not rece Resident #2 reported receiving his medical. An interview was con 10/10/17 at 4:03 PM the investigation that allegation of neglect report dated 10/3/17 investigation revealed medications as given still in the medication Resident #2 was one eMAR was reviewed. The DON revealed the corroborating statem well as 3 additional as was suspected Nurse medications for these administered them. A follow up interview DON on 10/11/17 at following the investig of the information are any harm to the resistent interviewed Nurse signed out medical not administered the additionally admitted.	ions. He identified the nurse icated he had no negative siving the medications. Inducted with the DON on a large service with the DON on a large service with the policy of the reviewed the results of the referred to in the 24-hour and the resident was an earl. She confirmed the earlier of the residents whose and during the investigation. The policy of the resident was an earlier than oriented residents it was altert and oriented residents it was altert and oriented residents it was conducted with the residents and had not was conducted with the 10:12 AM. She stated that gation, the PA was informed and she had no concerns of dents. The DON indicated see #1 on 10/3/17. She stated wiew Nurse #1 acknowledged cations in the eMAR and had	F 514		
	She stated that since	iew with the DON continued. e Nurse #1 was terminated r issues reported. She stated			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345534	B. WING	_		10/	11/2017
	ROVIDER OR SUPPLIER) HEALTH & REHABILITA	ATION CO		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 514	she interviewed a few were no additional co to three days followin investigation she obset (7:00 PM to 7:00 AM) Nurse #3) to ensure radministered timely a indicated there were a DON reported there were attended to this issue, issue was caused by terminated the issue I save was caused by terminated in multiple spinal stenosis, chronneuropathy, and insort he admission Minimassessment dated 9/2 #14 's cognition was scheduled pain medications. Resider antidepressant medications. Resider antidepressant medications are selected antidepressant medication in incident that on a prevance form was for an incident that on a reconstitution in the consistency of the grievance form was for an incident that on a prevance form was for an incident that on a prevance of the grievance form was for an incident that on a prevance of the grievance form was for an incident that on a prevance of the grievance filed, 5-day report was terminated.	r families to ensure there ncerns. She stated for two g the completion of the erved two of the second shift nurses (Nurse #2 and nedications were nd as documented. She no issues observed. The was no ongoing monitoring She stated she believed the Nurse #1 and since she was nad been resolved. admitted to the facility on diagnoses that included nic pain, hyperlipidemia, mnia. um Data Set (MDS) 28/17 indicated Resident fully intact. He received eations and as needed pain not #14 was administered ation on 7 of 7 days during eriod. a completed by Resident #14 courred on 10/3/17. The ence read, "[Resident #14] eive his medication one eive them until 2:30 AM the receive action by facility to indicated a 24-report was as filed, and the nurse was dicated his evening	F	514			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345534	B. WING _			C 10/11/2017
	ROVIDER OR SUPPLIER HEALTH & REHABILIT.	ATION CO		STREET ADDRESS, CITY, STATE, ZIP 2702 FARRELL ROAD SANFORD, NC 27330	CODE	10/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BI THE APPROPRIA	DATE
F 514	(dietary supplement of Trazodone (antidepre Metoprolol (beta-block A 24-hour initial report facility Administrator The allegation/incide neglect. The report in occurred on 10/2/17 times of 7:00 PM and description read, "Refered resident that [Nurse at offer medications durilisted on the report at the An Employee Couns indicated Nurse #1 minarrative of this notice to administer resident medications as given still in the medication administer tube feed of The 5-working day refered to in completed on 10/3/11 narrative of the invested MARs revealed that medications in eMAR card, indicating that readministration of these A phone interview was on 10/10/17 at 11:00	lyl (laxative), Melatonin utilized as sleep aid), essant medication), and oker). In the was completed by the in Training (AIT) on 10/3/17. In the was listed as resident indicated the incident through 10/3/17 between the intrough 10/3/17 between the intrough 10/3/17 between the intrough 10/3/17 between the indicated complaints from in it is in the accused individual. In the with the DON. The indicated Nurse #1 failed it is in medication was in card, and failed to ing as ordered. In the was completed by the allegation of resident in the 24-hour initial report in indicated a review of it is that were still in medication in the indicated in medication in the indicated in the electron indicated in medication in the indicated in well allegation indicated a review of it is that were still in medication in the indicated in the indicated in medication in the indicated in the indicated in medication in the indicated in medication in the indicated in the indication	F	514		
	An interview was cor	nducted with Resident #14 on				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345534	B. WING		C 10/11/2017	
NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 514	information in the grincident on 10/3/17 his evening medications where every distributed in the interview was considered in the investigation of neglect report dated 10/3/17 investigation reveals medications as give still in the medication Resident #14 was one MAR was reviewed The DON revealed to corroborating staten well as 3 additional was suspected Nurs medications for the administered them. A follow up interview DON on 10/11/17 at following the investigation and the interviewed Nurs harm to the resistent well as 3 additional was suspected Nurs medications for the sadministered them.	A. Resident #14 confirmed the rievance related to the in which he had not received tions one night and another is medications several hours he nurse who was assigned to be indicated there were no atted to this issue. Resident ther concerns with receiving and to the there in the polymer of the twas conducted for the interest of the treferred to in the 24-hour and the polymer of the ed Nurse #1 had signed out in when the medication was in card. She confirmed the neof the residents whose diduring the investigation. The polymer of the residents it is effect and oriented residents it is effect that gration, the PA was informed and she had no concerns of idents. The DON indicated is effect to the effect of the polymer of the pol	F 514			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 10/11/2017
	NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO			STREET ADDRESS, CITY, STATE, ZIP COD 2702 FARRELL ROAD SANFORD, NC 27330	DE	10/11/2017
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	TIVE ACTION SHOULD BE COMICED TO THE APPROPRIATE	
F 514	She stated that since there were no further she interviewed a few were no additional or to three days followir investigation she obsequence (7:00 PM to 7:00 AM Nurse #3) to ensure administered timely a indicated there were DON reported there related to this issue.	ew with the DON continued. Nurse #1 was terminated rissues reported. She stated w families to ensure there concerns. She stated for two ng the completion of the served two of the second shift nurses (Nurse #2 and medications were and as documented. She no issues observed. The was no ongoing monitoring She stated she believed the Nurse #1 and since she was	F	514		
	1/12/16 and most red with multiple diagnos hypertension, atrial f hyperlipidemia. The 30-day Minimum assessment dated 8, #15's cognition was scheduled pain mediadministered anticoagulant medicathe MDS look back pmedication on 3 of 7	ibrillation, depression, and n Data Set (MDS) /14/17 indicated Resident fully intact. She received cations. Resident #15 was pressant medication and ation on 7 of 7 days during period. She received diuretic				
	for an incident that o narrative of the griev stated she had not re	completed by Resident #15 ccurred on 10/2/17. The ance indicated Resident #15 eceived her medications one ght she received them really				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING _	(X3) DATE SURVEY COMPLETED C		
		345534	B. WING		10/11/2017	
	NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO			TREET ADDRESS, CITY, STATE, ZIP CODE 702 FARRELL ROAD SANFORD, NC 27330	10/11/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 514	the grievance indic 5-day report was fil terminated. A review of Reside in place on 10/2/17 medications were medication), Atorva medication), Mapa (beta-blocker), and A 24-hour initial regracility Administrated The allegation/incid neglect. The report occurred on 10/2/1 times of 7:00 PM a description read, "Fresident that [Nurse offer medications of listed on the report An Employee Cour indicated Nurse #1 narrative of this not to administer reside medications as given still in the medication administer tube feet. The 5-working day AIT on 10/6/17. Trineglect referred to	e action by facility to resolve ated a 24-report was filed, led, and the nurse was int #15's physician's orders indicated his evening frazodone (antidepressant astatin (high cholesterol po (acetaminophen), Metoprolol Eliquis (anticoagulant). Foort was completed by the por in Training (AIT) on 10/3/17. Ident type was listed as resident at indicated the incident from the portion of the port of the portion of the portion of the portion of the portion of	F 514			
	completed on 10/3, narrative of the invo eMARs revealed th medications in eMA	in the 24-hour initial report /17 was substantiated. The estigation indicated a review of hat Nurse #1 signed off multiple AR that were still in medication t nurse falsely documented the				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345534	B. WING		10/11/2017	
	ROVIDER OR SUPPLIER HEALTH & REHABILI	TATION CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		10/11/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 514	on 10/10/17 at 11:0 provide any informal An interview was con 10/10/17 at 4:03 PM the investigation of neglect report dated 10/3/12 investigation reveal medications as given still in the medication Resident #15 was continued to the DON revealed corroborating stater well as 3 additional	ese medications. It was conducted with Nurse #1 If AM. Nurse #1 declined to to tion during the interview. If Amounted with the DON on the interview of the results of the interview of the residents whose interview of the investigation.	F 514			
	administered them. An interview was considered to AM information in the granded incident on 10/2/17 her evening medical night she received hate. She identified to her as Nurse #1. negative effects related to the incident on further than the incident on the incident of	and and not and and not and action action and action actio				

NAME OF P		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		·	(X3) DATE SURVEY COMPLETED	
NAME OF P		345534	B. WING		C 10/11/2017	
NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	10.11/2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 514	any harm to the resishe interviewed Nursthat during the interviewed seek signed out medinot administered the additionally admitted feeding as administered tube feeding. This follow up interviewed a few were no furthe she interviewed a few were no additional of to three days following investigation she observed the seek administered timely indicated there were administered timely indicated there were DON reported there related to this issue, issue was caused by terminated the issue seek and 10/16/14 with multiple neuropathy, insomning hyperlipidemia. The annual Minimum assessment dated 9	dents. The DON indicated se #1 on 10/3/17. She stated riew Nurse #1 acknowledged cations in the eMAR and had medications. She I to documenting a tube gred without administering the ew with the DON continued. It is not set without administering the ew with the DON continued. It is not set without administering the ew with the DON continued. It is not set without administering the ew with the DON continued. It is not set without administering the ew with the DON continued. It is not set with the DON continued. It is not set with the provided in the set of the set with the provided in the prov	F 51	4		
	to three days following investigation she observed for 100 PM to 7:00 AM Nurse #3) to ensure administered timely similar and the reported there are related to this issue, issue was caused by terminated the issue for the following for the following for the following for the following fo	ng the completion of the served two of the second shift I) nurses (Nurse #2 and medications were and as documented. She no issues observed. The was no ongoing monitoring She stated she believed the Nurse #1 and since she was had been resolved. I admitted to the facility on le diagnoses that included a, anxiety, and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING			C 10/11/2017
	NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		10/11/2017
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 514	in place on 10/2/17 in medications were Cl medication), Trazodo medication), Atorvas medication), Neuron and Divalproex Sodion A 24-hour initial report acility Administrator The allegation/incide neglect. The report in occurred on 10/2/17 times of 7:00 PM and description read, "Regresident that [Nursest offer medications dulisted on the report and An Employee Couns indicated Nurse #1 in narrative of this notice to administer resident."	#16 's physician 's orders indicated his evening on azepam (antianxiety one (antidepressant tatin (high cholesterol tin (nerve pain medication), aum (mood stabilizer). In the was completed by the in Training (AIT) on 10/3/17. In the type was listed as resident indicated the incident through 10/3/17 between the detail of the type was listed as resident indicated the incident through 10/3/17 between the detail of the type was listed as resident indicated the incident through 10/3/17 between the detail of the type was listed as the accused individual. The with the DON. The resident in the medication was a card, and failed to	F 51	4		
	AIT on 10/6/17. The neglect referred to in completed on 10/3/1 narrative of the invested that medications in eMAF card, indicating that administration of the A phone interview was	eport was completed by the allegation of resident the 24-hour initial report 7 was substantiated. The stigation indicated a review of t Nurse #1 signed off multiple R that were still in medication nurse falsely documented the se medications. as conducted with Nurse #1 AM. Nurse #1 declined to				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED		
		345534	B. WING		C 10/11/2017	
	NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO			REET ADDRESS, CITY, STATE, ZIP CODE 02 FARRELL ROAD NFORD, NC 27330	10/11/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 514	An interview was co 10/10/17 at 4:03 PM the investigation the allegation of neglec report dated 10/3/1 investigation reveal medications as give still in the medication was verified through #16 had a controlle that was signed off but it was not signe sheet and it remain. A follow up interview DON on 10/11/17 a following the investion of the information a any harm to the result she interviewed Nuthat during the interviewed Nuthat during the interviewed Nuthat during the interviewed additionally admitted feeding as administrative feeding. This follow up interviewed as a feeding. This follow up interviewed a feeding and ditional to three days follow investigation she obtained to the stated that since the stated that s	ation during the interview. Inducted with the DON on M. She reviewed the results of at was conducted for the treferred to in the 24-hour Town She indicated the ed Nurse #1 had signed out en when the medication was on card. The DON stated it in eMAR review that Resident in the eMAR as administered, in the eMAR as administered, in the eMAR as administered, in the medication cart. In was conducted with the into 12 AM. She stated that in the medication cart. In was conducted with the into 12 AM. She stated that in the medication cart. In was conducted with the into 13 AM. She stated that in the medication cart. In was conducted with the into 14 AM. She stated that in the medication cart. In was conducted with the into 14 AM. She stated that in the medication in the eMAR and had be medications. The DON indicated in the into 16 AM. She stated without administering the into 16 AM. She stated in the medications. She into 16 AM. She stated for two into the into 16 AM. She stated for two into the completion of the into 16 AM. She stated for two into the completion of the into 16 AM. She stated for two into the completion of the into 16 AM. She stated for two into the completion of the into 16 AM. She stated for two into the into 16 AM. She stated for two into the second shift into 16 AM. She stated for two into the into 16 AM. She stated for two into the into 16 AM. She stated for two into the into 16 AM. She stated for two into 16 AM. S	F 514			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING			C 10/11/2017	
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	I	10/11/2017	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 514	indicated there were DON reported there related to this issue.	no issues observed. The was no ongoing monitoring She stated she believed the Nurse #1 and since she was	F 5	14			
	4/5/16 and most rece with multiple diagnos s and schizophrenia. The quarterly Minimu	um Data Set (MDS) dated					
	severely impaired. In medications. Reside antipsychotic medical medication 7 of 7 da period. He received 7 days and antianxie	esident #17 's cognition was the received scheduled pain ent #17 was administered ation and antidepressant ys during the MDS look back antibiotic medication on 5 of ety medication on 1 of 7 days. ed 51% or more of his seeding.					
	#17 indicated Isosou feeding formula) at 6	dated 9/13/17 for Resident arce 1.5 (nutritional tube 5 milliliters (ml)/hour (hr) ostomy tube (g-tube) once					
		s note dated 9/13/17 17 's diet was NPO (nothing as ordered continuous tube					
	Manager for an incid Resident #17 on 10/2	was completed by the Unit ent that occurred with 2/17. The narrative of the 10/2/17 I was called into					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345534	B. WING		10/11/2017	
NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	10.1.1.2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 514	Continued From pag	ge 56	F 514			
	entering the room [Rup to any tube feeding tubing was not connot an Employee Counsindicated Nurse #1 runarrative of this notice to administer resider medications as given still in the medication administer tube feed A phone interview won 10/10/17 at 11:00 provide any information and interview was considered and interview.	as conducted with Nurse #1 AM. Nurse #1 declined to the tion during the interview. Inducted with the DON on which inducted with the DON indicated she in 10/3/17. She stated that which inducted with				
	stated that since Nur were no further issue interviewed a few far no additional concer three days following observed two of the AM) nurses (Nurse # tube feedings and m	rse #1 was terminated there es reported. She stated she milies to ensure there were ns. She stated for two to the report of the incident she second shift (7:00 PM to 7:00 #2 and Nurse #3) to ensure sedications were administered mented. She indicated there				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IG	I COM	(X3) DATE SURVEY COMPLETED	
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	345534	B. WING _		10)/11/2017	
			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD			
H & REHABILITA	ATION CO		SANFORD, NC 27330			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE	
nued From page	e 57	F 5	14			
was no ongoing She stated sho d by Nurse #1 a lated the issue	y monitoring related to this e believed the issue was and since she was had been resolved.					
ger on 10/11/17 itten statement ent #17 not beir g as ordered or lly came into wo ed she was not or nurse shortly ed the tube feet ot connected to ted Nurse #1 ha ent #17 the pre ger stated she w ent #17 had not eported she hoc ent #17, she inf	at 1:50 PM. She confirmed she completed about a administered his tube an 10/2/17. She stated she ork around 8:00 AM so she ified of this information by after 8:00 AM. She ding bag was hanging, but it a Resident #17. She ad been assigned to vious shift. The Unit was unsure how long to received his tube feeding to formed the DON, and she					
	SUMMARY ST (EACH DEFICIENC REGULATORY OR I nued From page no issues obser was no ongoing. She stated she deby Nurse #1 a nated the issue erview was con ger on 10/11/17 ritten statement ent #17 not bein ng as ordered or ally came into we red she was not or nurse shortly ted the tube fee- ot connected to ted Nurse #1 ha ent #17 the pre ger stated she we ent #17 had not eported she hoc ent #17, she inf	S OR SUPPLIER TH & REHABILITATION CO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Thued From page 57 Ino issues observed. The DON reported was no ongoing monitoring related to this. She stated she believed the issue was and by Nurse #1 and since she was nated the issue had been resolved. The erview was conducted with the Unit ger on 10/11/17 at 1:50 PM. She confirmed ritten statement she completed about ent #17 not being administered his tube and as ordered on 10/2/17. She stated she ally came into work around 8:00 AM so she end she was notified of this information by for nurse shortly after 8:00 AM. She need the tube feeding bag was hanging, but it not connected to Resident #17. She ted Nurse #1 had been assigned to ent #17 the previous shift. The Unit ger stated she was unsure how long ent #17 had not received his tube feeding to ent #17, she informed the DON, and she	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG PREFIX (EACH CORRECTIVE ACTIONS TAG PREFIX T	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) THOUGH From page 57 Into issues observed. The DON reported was no ongoing monitoring related to this She stated she believed the issue was d by Nurse #1 and since she was nated the issue had been resolved. erview was conducted with the Unit ger on 10/11/17 at 1:50 PM. She confirmed ritten statement she completed about ent #17 not being administered his tube ga as ordered on 10/2/17. She stated she lilly came into work around 8:00 AM so she ed she was notified of this information by or nurse shortly after 8:00 AM. She ed the tube feeding bag was hanging, but it of connected to Resident #17. She ted Nurse #1 had been assigned to ent #17 the previous shift. The Unit ger stated she was unsure how long ent #17 had not received his tube feeding to ent #17, she informed the DON, and she	