PRINTED: 12/04/2017 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345051	B. WING		10/26/2017
	ROVIDER OR SUPPLIER	ATION	STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170		•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 242 SS=D	CHOICES CFR(s): 483.10(f)(1)- (f)(1) The resident has schedules (including health care and proviconsistent with his or and plan of care and of this part. (f)(2) The resident has about aspects of his care significant to the example of the common than the significant to the example of the common than the fact of the common than the common that t	s a right to choose activities, sleeping and waking times), ders of health care services her interests, assessments, other applicable provisions s a right to make choices or her life in the facility that resident. s a right to interact with munity and participate in both inside and outside the is not met as evidenced terview, staff interview, and cility failed to provide d to 1 of 1 residents ewed for choices. The dmitted to the facility on diagnoses that included, repeated falls, iscle weakness. sum Data Set (MDS) 1/17 indicated Resident interest was assessed are and no behaviors. ed extensive assistance of 1 d mobility, transfers, t, dressing, toileting, and	F 24	Disclaimer Clause: Preparation and or execution of this p does not constitute admission or agreement by the Provider of the truth facts alleged or conclusion set forth or statement of deficiencies. The plan is prepared and executed solely becaus is required by the provisions of State as Federal law. F 242 Resident #116 was provided a shower 10/26/17 on the 3pm to 11pm shift. The resident was discharged to her home 10/27/17. The monitoring of care had been provided by the charge nurse to assure that showers are being done.	r he on not
ARORATORY	I DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATURI	<u>(</u>	TITLE	(X6) DATE

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

Electronically Signed

11/17/2017

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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		E SURVEY MPLETED
		345051	B. WING _		10	0/26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	00
				405 SOUTH GREENE STREET		
ANSON H	EALTH AND REHABII	LITATION		WADESBORO, NC 28170		
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F 242	Continued From page	age 1	F 2	42		
	dependent on 1 sta Resident #116 was feet and unable to assistance. She h her admission to the The plan of care for 9/7/17, indicated s Activities of Daily L interventions include for Resident #116. The shower sched she was scheduled Thursdays on the standard of the PM). A review of the Resident #116 's at 10/23/17 revealed	aff member for bathing. Is coded as unsteady on her stabilize without staff and one fall in the month prior to the facility. In Resident #116, initiated on the required assistance with a civing (ADL) tasks. The ded physical help with bathing the for showers on Mondays and the second shift (3:00 PM to 11:00 the shower documentation from the admission on 8/25/17 through the Resident #116 received 1	1 2	A 100% audit was initiated Worker on 10/27/17 of all redetermine bathing preferen 11/1/17, the Social Worker 100% of alert and oriented determine that they are recebath or shower as schedule two residents reported they receiving showers; howeve documentation indicated or residents received frequent the other resident had refuse The Unit Manager visually inon-interviewable residents cleanliness and well-kept a negative findings were four	esidents to ce. On interviewed residents to eiving their ed. As a result, were not r, ne of the showers and sed showers. inspected all s to determine ppearance. No	
	on 10/23/17 at 3:5 she enjoyed show assistance of staff she recalled only r since her admission stated she had not were supposed to reported she had receiving showers way it was supposed to received assistance hygiene as needed.	conducted with Resident #116 5 PM. Resident #116 reported ers and she required the with showers. She indicated ecciving a couple of showers in to the facility (8/25/17). She known what days her showers be provided on. Resident #116 not complained about not as she assumed this was the ed to be as she had not ever efore. She indicated she had e with bed baths and personal diff.		physical assessment by the As of 11/1/17, moving forward Minimum Data Set Nurse wupdated resident care plans guides by 11/13/17 for bath preferences. A 100% in-service was initially the Director of Nursing at Manager for all nursing stat bathing preferences and shadele. This in-service work completed by 11/17/17. No member will be allowed to vereceive this in-service. All newly hired nursing staff the training during orientation.	ard, The will have s and care s and care ated on 11/1/17 and Unit ff regarding nower ill be clinical staff work until they	
	10/25/17 at 9:40 A	conducted with Nurse #2 on M. She stated she was familiar S and she was unaware of her staff.		the training during orientation Utilizing the shower scheduled and verify reside	ile, the Unit ily shower	

STATEMENT OF DEFICIENC AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY
		345051	B. WING _			10/	26/2017
NAME OF PROVIDER OR	SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ANSON HEALTH AND	DELIABII IT	ATION		40	5 SOUTH GREENE STREET		
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	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
An interview Assistant stated she of 2017 at shift (3:00 was familial Resident including admitted to admission rehabilitate as much at Resident including admitted to received the shift of	(NA) #1 on e had worke had she norm PM to 11:0 ar with Res #116 require bathing and to the facility, Resident sion services assistance we was cone explain why her showers was cone indicated significant for the second indicated significant for the second indicated significant for the second py Resident as schedule lew was cone poon on 10 expected for the second for	ducted with Nursing 10/25/17 at 3:50 PM. She d at the facility since March nally worked on the second 0 PM). She indicated she ident #116. She reported ed assistance with ADLs showers when she was first v. She stated since her #116 had been receiving and she had not required with ADLs. NA #1 indicated of refused care. She was v. Resident #116 had not as scheduled. ducted with NA #2 on She stated she had worked ay of 2017 and she normally d shift (3:00 PM to 11:00 he was familiar with reported Resident #116 ance with ADLs due to A #2 indicated Resident care. She was unable to #116 had not received her	F 2		schedule for a shower actually received shower. From 11/1/17 moving forward, the floor nurse has been responsible for asking residents being monitored if they receive a shower or not. Monitoring will include random residents to occur Monday through Friday x 2 weeks, then 3 random residents twice weekly x 2 weeks, then random residents weekly x 1 month, th 3 random residents monthly x 1 month ensure showers were given as scheduled in the resident chart. The results of the shower audits will be reviewed by the Director of Nursing weekly x 4 weeks, then every 2 weeks 2, the monthly x 1 month by the Director of Nursing for trends or concerns. The Director of Nursing will present the results of the monitoring at the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting monthly for 3 months for review and recommendations for any modification the monitoring process.	the yed 3 om 3 en to led. son he	11/17/17

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F 278	(h) Coordination A registered nurse meach assessment with participation of health (i) Certification (1) A registered nurse the assessment is considered nurse the assessment is considered nurse that portion of the assessment must significate that portion of the assessment must significate that portion of the assessment must significate that portion of the assessment is under the properties of the properti	ust conduct or coordinate the the appropriate in professionals. e must sign and certify that empleted. tho completes a portion of the in and certify the accuracy of sessment. eation and Medicaid, an individual wingly- all and false statement in a is subject to a civil money than \$1,000 for each andividual to certify a material in a resident assessment is ey penalty or not more than	F 2	278		
	material and false sta This REQUIREMENT by: Based on record rev facility failed to accur the diagnosis of depr Minimum Data Set (N			F 278 The last Minimum Data assessment completed was reviewed by MDS 0	for resident #64	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		405 SOUTH GREENE STREET			
ITATION		WADESBORO, NC 28170			
STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE	
admitted on 8/11/17 with ses of depression, chronic pain art failure. S dated 8/18/17 indicated wed an antidepressant ays for the look back period. Expression was not coded. The Area dated 8/18/17 triggered edications and indicated she depressant and it would be care planned on 8/24/17 for dication use. 10/25/17 at 12:40 PM, MDS eglected to code the depression and would ation MDS. 10/25/17 at 4:20 PM the stated she was responsible to assessments completed by drit was her expectation the dit was his expectation that DS would have been coded for	F 27	10/25/17 and Section I was more include the diagnosis of Depress accurately reflect the residents condition. A 100% audit of the last complete assessment for all residents, to resident # 64, will be conducted Regional Reimbursement Mana (RRMs) to be completed by 11/ensure coding of the minimum of accurately reflects the residents errors were found in the diagnor in section I of the MDS by 11/17 For all areas of concern identification or significant correspior assessment (Quarterly/Comprehensive) will completed by the facility MDS № 11/17/17. The MDS Nurse, Dietary Managand Activities Director (AD) will re-in-serviced on proper coding assessments per the Resident Assessment Instrument (RAI) № the RRM to be completed by 11 When coding the MDS assessment MDS Nurses and Care Plan Teafollow the instructions for proper found in the Resident Assessment Instrument (RAI) Manual and enthe assessment accurately refleresident scurrent condition. Ar	eted MDS include I by agers 17/17 to data set S. No sis coding 7/17. ed, a ction of be Nurse by ger (DM), be of MDS Manual by /17/17. nent the am will r coding ent nsure that ects the n audit of		
	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ge 4 admitted on 8/11/17 with es of depression, chronic pain art failure. S dated 8/18/17 indicated yed an antidepressant ays for the look back period. expression was not coded. The area dated 8/18/17 triggered edications and indicated she expressant and it would be care planned on 8/24/17 for dication use. 0/25/17 at 12:40 PM, MDS eglected to code the depression and would ation MDS. 0/25/17 at 4:20 PM the stated she was responsible to assessments completed by d it was her expectation that	B. WING	STATEMENT OF DEFICIENCIES ID PREFIX (EACH CORRECTIVE ACTIONS ACROSS-REFERENCED TO THE AID DEFICIENCY) F 278 10/25/17 and Section I was moninclude the diagnosis of Depress accurately reflect the residents condition. A 100% audit of the last comple assessment for all residents, to resident # 64, will be conducted. Regional Reimbursement Mana (RRMs) to be completed by 11/1 ensure coding of the minimum of accurately reflects the residents errors were found in the diagno in section I of the MDS by 11/1 ensure coding of the minimum of accurately reflects the residents errors were found in the diagno in section I of the MDS by 11/1. For all areas of concern identific modification or significant corre prior assessment (Quarterly/Comprehensive) will completed by the facility MDS N 11/17/17. The MDS Nurse, Dietary Mana and Activities Director (AD) will re-in-serviced on proper coding assessments per the Resident Assessment Instrument (RAI) Manual and et the assessment accurately reflect in the assessment accurately reflect the residents and Activities Director (AD) will be conducted the director of the modification or significant corre prior assessment instrument (RAI) Manual and et the assessment accurately reflect the resident accurately reflect the	STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170 STATEMENT OF DEFICIENCIES WOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) GREEN GROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) GREEN TAG F 278 10/25/17 and Section I was modified to include the diagnosis of Depression to accurately reflect the residents current condition. A 100% audit of the last completed MDS assessment for all residents, to include resident # 64, will be conducted by Regional Reimbursement Managers (RRMs) to be completed by 11/17/17 to ensure coding of the minimum data set accurately reflects the residents. No errors were found in the diagnosis coding in section I of the MDS by 11/17/17. For all areas of concern identified, a modification or significant correction of prior assessment (Quarterly/Comprehensive) will be completed by the facility MDS Nurse by 11/17/17. The MDS Nurse, Dietary Manager (DM), and Activities Director (AD) will be re-in-serviced on proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual by the RRM to be completed by 11/17/17. When coding the MDS assessment the MDS Nurses and Care Plan Team will	

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F 279 SS=D	CFR(s): 483.20(d);48 483.20 (d) Use. A facility mu assessments complemonths in the resider results of the assessment revise the resider plan. 483.21 (b) Comprehensive Comprehensive Comprehensive personal comprehensive personal comprehensive personal comprehensive personal comprehensive comprehensive personal comprehen	HENSIVE CARE PLANS 3.21(b)(1) st maintain all resident ted within the previous 15 it's active record and use the ments to develop, review int's comprehensive care		RRM to ensure compliance and accutilizing a MDS audit Tool. All identified areas of concern will be addressed immediately by the RRM retraining appropriate staff responsished the coding error and by the MDS Nowith modification or significant corresponds of the MDS. The Administrator will reand initial the MDS Audit Tool weeks weeks, then bi-weekly x 4 weeks the monthly x 1 month. The results of the MDS Audit Tool weeks compiled by the Administrator and presented to the Quality Improvement Committee monthly x 3 months. Identification of trends will determinated for further action and/or change frequency of required monitoring.	by ble for rse ction eview y x 4 en Il be nt	11/17/17	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 279	includes measural to meet a resident and psychosocial comprehensive as care plan must de (i) The services the or maintain the resphysical, mental, a required under §44 (ii) Any services the under §483.24, §4 provided due to the under §483.10, incomprehensive services are a result recommendations findings of the PAS rationale in the resident's representation of the resident's desired outcomes. (B) The resident's future discharge. If whether the resident community was as	O(c)(2) and §483.10(c)(3), that ble objectives and timeframes is medical, nursing, and mental needs that are identified in the sessment. The comprehensive scribe the following - at are to be furnished to attain sident's highest practicable and psychosocial well-being as 83.24, §483.25 or §483.40; and att would otherwise be required 83.25 or §483.40 but are not e resident's exercise of rights bluding the right to refuse 483.10(c)(6). If a facility disagrees with the SARR, it must indicate its sident's medical record. with the resident and the intative (s)- goals for admission and preference and potential for facilities must document ent's desire to return to the seessed and any referrals to cies and/or other appropriate	F 2	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279		e 7 In the comprehensive care in accordance with the	F 27	79	
	requirements set forti section. This REQUIREMENT by: Based on record rev facility failed to devel accurate plan of care Living (ADLs) for 1 of reviewed for choices. Resident #116 was a 8/25/17 with multiple unsteadiness on feet osteoporosis, and mu The admission Minimassessment dated 9/#116 's cognition wa required the extensive member with bed moon/off unit, dressing, hygiene. The plan of care for Fin the Electronic Med 10/24/17 at 12:29 PM for Resident #116 ap requiring the reader the plan read, in part, "(Sassistance with ADL management of incorriogecify diagnosis or problem area read, "(participate in ADLs at the plan and the participate in ADLs at the plan and the participate in ADLs at the plan and t	in in paragraph (c) of this is not met as evidenced iew and staff interview, the op an individualized and related to Activities of Daily if 1 residents (Resident #116) The findings included: dmitted to the facility on diagnoses that included repeated falls, uscle weakness. hum Data Set (MDS) 1/17 indicated Resident is intact. Resident #116 e assistance of 1 staff bility, transfers, locomotion toileting, and personal Resident #116 was reviewed ical Record (EMR) on i. Portions of this care plan peared to be generic, of ill in the blank. The care specify name) needs tasks daily including the ntinence secondary to reason)". The goal for this (Specify name) will actively is is able to tolerate and		F 279 The care plan for resident #116 was reviewed and update by the MDS Coordinator on 10/25/17 to accuratel reflect the assistance the resident requires for activities of daily living, including bed mobility, transfers, locomotion on/off unit, dressing, toile and personal hygiene, and related diagnosis. In addition the care plan wupdated to remove the intervention of Mechanical Lift which was not current being utilized to transfer the resident. A 100 % audit of all residents care plan will be conducted by Regional Reimbursement Manager (RRM) by 11/17/17, including the care plan for resident #116 to ensure comprehensing care plans have been developed per comprehensive assessment. The care plans were updated for any identified areas of concern by utilizing CAA s from last comprehensive assessment, progress notes, medical administration records, and treatment records to ensure the care plans add the resident current medical, nursimental, and psychosocial needs as	ting, vas f tily ans ive the tion t ress
	member with bed mo on/off unit, dressing, hygiene. The plan of care for Fin the Electronic Med 10/24/17 at 12:29 PM for Resident #116 ap requiring the reader the plan read, in part, "(Sassistance with ADL management of incorrespecify diagnosis or problem area read, "(participate in ADLs as perform through next)."	bility, transfers, locomotion toileting, and personal Resident #116 was reviewed ical Record (EMR) on 1. Portions of this care plan peared to be generic, of ill in the blank. The care specify name) needs tasks daily including the ntinence secondary to reason)". The goal for this (Specify name) will actively is is able to tolerate and review". The interventions lizing a mechanical lift with		will be conducted by Regional Reimbursement Manager (RRM) by 11/17/17, including the care plan for resident #116 to ensure comprehens care plans have been developed per comprehensive assessment. The care plans were updated for any identified areas of concern by utilizing CAA s from last comprehensive assessment, progress notes, medica administration records, and treatmen records to ensure the care plans add	ive the g tion t ress ng,

	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		\ /	(X3) DATE SURVEY COMPLETED		
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				405 SOUTH GREENE STREET		
ANSON H	EALTH AND REHABILIT	ATION		WADESBORO, NC 28170		
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F 279	Continued From page	e 8	F 27	9 11/17/17.		
	#116 's plan of care MDS Nurse.	PM a hard copy of Resident was requested from the PM the MDS Nurse provided		No negative findings were noted d the care plan audit. The MDS Coordinator, Dietary Ma and Activity Director were educate	ınager,	
	a hard copy of Resident #116 's plan of care. The plan of care related to ADLs for Resident #116 was reviewed with the MDS Nurse. This plan of care had been revised to include Resident #116 's name, her related diagnoses, and to remove			care planning requirements, per instructions provided in the RAI Mark RRM and on 11/16/17. The in-ser was completed on 11/16/17.	anual by	
	the intervention of a mechanical lift with 2 persons assistance for transfers. The MDS Nurse revealed she had revised the plan of care for Resident #116 on this date, 10/24/17, after a hard copy was requested for review. She stated			RRM will review all resident care princlude resident #116, in comparist triggered Care Area Assessments subsequent comprehensive asses 24 hour reports, shift change note:	son to on all ssments,	
	#116 's name, her re removal of the interve with 2 persons assist MDS Nurse indicated	d the addition of Resident elated diagnoses, and the ention for the mechanical lift ance for transfers. The d she was not sure why		progress notes, current intervention physician telephone orders 5 x per 4 weeks, then an audit of 10% of the plans weekly x 3 months to ensure care plans reflect the residents current.	r week x care e that	
	had not been specified this date, 10/24/17.	me and related diagnoses ed on her plan of care prior to She revealed this was an se additionally indicated the hanical lift with the 2		medical, nursing, mental, and psychosocial needs utilizing a care audit tool. The MDS Nurse will immediately under the model of the model.		
	persons assistance for She revealed Reside	or transfers was an error. nt #116 had never required a nsfers since her admission		the care plan for all identified area concerns and the Administrator or will provide retraining with the idenstaff member.	s of RRM	
	Nursing on 10/25/17 her expectation was	aducted with the Director of at 11:05 AM. She indicated for plans of care to be accurate representation of		The results of the care plan audit to be compiled by the Administrator apresented to the Quality Improvem Committee monthly x 3 months. Identification of trends will determineed for further action and/or charfrequency of required monitoring. Completion Date: 11/17/17	and nent ine the	

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NAME OF PI	ROVIDER OR SUPPLIER	-		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
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ANSON H	EALTH AND REHABIL	ITATION		W	ADESBORO, NC 28170		
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F 281 SS=D	STANDARDS CFR(s): 483.21(b)((b)(3) Comprehens The services provid as outlined by the comust- (i) Meet profession. This REQUIREMED by: Based on record reinterview, the facility after the dressing of the treatment order Physician's order and Administration Recorded resident reviewed for #71). Findings include 1a. Resident #71 with 11/5/12 with multiples sacral pressure ulco Data Set (MDS) as indicated that Resident #71's elector order dated 10/16/10 pressure ulcor to set of the service order to set of the services and she had a stage of the services or the services of	ded or arranged by the facility, comprehensive care plan, al standards of quality. NT is not met as evidenced eview, observation and staff ty failed to date the dressing change and failed to transcribe recorrectly to the electronic and electronic Treatment ord (TAR) for 1 of 1 sampled for pressure ulcer (Resident uded: vas admitted to the facility on the diagnoses including stage 4 there. The quarterly Minimum sessment dated 9/7/17 dent #71's cognition was intact the 4 pressure ulcer. ctronic physician' orders for a reviewed. There was an 17 to "cleanse stage 4 the acrum with wound cleanser,	F 2	281	F281 The dressing for Resident #71 continu to be changed as ordered. The dressi had not been dated until 11/2/17 after nurse re-training. It was the facility practice not to date dressings, as the signature date on the electronic Treatm Administration Record signified which nurse completed the dressing change the ordered dressing and on what date was changed. Dressings have been dated when changed beginning 11/2/17 under the direction of the Director of Nursing. The Director of Nursing initiated an in-servity on 11/7/17 to the Treatment Nurse and licensed nurses that they are required date all dressings when applied. All new the direction of the direction of the Director of Nursing initiated.	nent on e it	11/17/17
	that helps with hea and to cover with d needed." On 10/25/17 at 8:4	G foam (a wound dressing ling and protect from infection) ry dressing daily and as 1 AM, Resident #71 was e dressing change. Nurse #6			nurses will receive the education. The education was completed on 11/17/17 and no nurses will work until have been educated. Beginning 11/13/17 Utilizing a Dressing	•	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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NAME OF PR	ROVIDER OR SUPPLIER		,	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
****		47.01		40	05 SOUTH GREENE STREET		
ANSON H	EALTH AND REHABILIT	ATION		V	VADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 281	(Treatment Nurse) was observed to clean the		F2	281	Audit Tool, the Unit Manager will comp	lete	
	Promogran AG foam	with wound cleanser, was applied and covered urse #6 was not observed to			a visual audit of 5 random wound dressings Monday through Friday x 2 weeks, then twice weekly to include weekends x 6 weeks, then twice month to include weekends x 1 month to assu	-	
	dating the dressing a	AM, Nurse #6 was ted that in the past, she was fter the dressing change but informed by the corporate			dressings are dated appropriately. The Director of Nursing will review and initial the audit tool weekly x 8, then		
	office not to date the	office not to date the dressing anymore. monthly x 1 for trends and cond		monthly x 1 for trends and concerns. T Dressing QI Audit Tools are turned in to			
	(DON) was interviewed she had received a m	PM, the Director of Nursing ed. The DON stated that nemo from the corporate			the Director of Nursing for review to ensure facility is compliant with current Plan of Correction. Problems identified		
		ssing after dressing change.			during the audits will be corrected by the Director of Nursing and the Plan of Correction will be revised as deemed	ie	
	11/5/12 with multiple sacral pressure ulcer	admitted to the facility on diagnoses including stage 4 . The quarterly Minimum			necessary to maintain Regulatory Compliance.		
	Data Set (MDS) asse indicated that Reside and she had a stage	nt #71's cognition was intact			The treatment order for Resident #71 v clarified by the Unit Manager on 10/25 and transcribed to the electronic Treatment Administration Record by th	17	
	October 2017 were re order dated 10/16/17	onic physician's orders for eviewed. There was an to "cleanse stage 4 rum with wound cleanser,			Unit Manager. The error in transcriptic occurred due to human error and the la of no verification by another nurse that order was transcribed correctly.	ack	
		foam and to cover with dry			On 10/30/17 a 100% audit of all the treatment orders was initiated by the U	nit	
	(eTAR) for October 2 eTAR indicated to "cl- ulcer to sacrum with	nent Administration Record 017 was reviewed. The eanse stage 4 pressure wound cleanse, apply and cover with dry dressing			Manager to ensure all orders were transcribed correctly. Thirteen orders were identified that included a PRN frequency. All thirteen orders were clarified and rewritten in the Electronic Health Record with separate PRN order This was completed by the Unit Mange		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		10/	26/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	•		
				405 SOUTH GREENE STREET			
ANSON H	EALTH AND REHABILIT	ATION		WADESBORO, NC 28170			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 281	Continued From pag	e 11	F 28	31			
	The eTAR for Octobe treatment to Residen was provided on Oct	t #71's sacral pressure ulcer		on 10/31/2017. There was outcome for any of the thirt			
	On 10/25/17 at 8:41 observed during the was observed to cleawith wound cleanser applied and covered On 10/25/17 at 10:52 interviewed. She stawho wrote the treatment order was times a week but she electronic physician's incorrectly. She acknown transcribed the treatment of the treatment of the treatment order was times a week but she electronic physician's incorrectly. She acknown transcribed the treatment of 3 time. On 10/25/17 at 10:55 order dated 10/16/17 provided by Nurse #6 "cleanse stage 4 prewound cleanser, approver with dry dressi PRN." On 10/25/17 at 2:28 (DON) was interview she expected the nur	AM, Resident #71 was dressing change. Nurse #6 in the sacral pressure ulcer, Promogran AG foam was with dry dressing. 2 AM, Nurse #6 was ted that she was the one tent order for Resident #71 se #6 indicated that the to change the dressing 3 e transcribed the order to the sorder and electronic TAR mowledged that she ment order to be changed		An in-service for 100% lices was initiated 11/1/17 by the Nursing on accurately transphysician orders. An additional was initiated by the Director 11/7/17 to all licensed nurse second signature for each porder to assure transcription from the written telephone electronic health record AH in-services were completed Nursing staff will be in-serviced working on the floor. All new licensed nurses will received during orientation. Beginning 11/13/17 Utilizing Orders Review QI audit too Manager will review each norder Monday through Fridathen twice weekly to include weeks, then monthly to include weeks, then monthly to include the twice weekly	e Director of scribing on al in-service or of Nursing on es requiring a physician □s on accuracy porder into the T. Both I by 11/17/17. iced prior to why hired the education of a Treatment of the Unit lew treatment all, the Unit lew treatment all are all are weekends x 6 and weekends are of the order or practice is		
		orrectly and to read the TAR		compliant with current Plan The Plan of Correction will deemed necessary to main Compliance. Any concerns corrected at the time of disc staff involved will be re-edu Director of Nursing will revi	be revised as tain Regulatory will be covery and the icated. The		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345051	B. WING _			10/26/2017	
	ROVIDER OR SUPPLIER EALTH AND REHABILIT	TATION	•	STREET ADDRESS, CITY, STATE, Z 405 SOUTH GREENE STREET WADESBORO, NC 28170	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE / CROSS-REFERENCED T	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 281	Continued From pag	e 12 LIFIED PERSONS/PER	F 2	the audit tools weekly x 1 for trends and concerr The Director of Nursing results of the monitoring Orders Audit Tool and th Tool to the monthly QI m to identify trends and co monitoring and recomme modification of the process.	will present the Treatment ne Dressing Audit neeting x 3 months ontinued need for endations for any	11/17/17	
SS=D	CARE PLAN CFR(s): 483.21(b)(3) (b)(3) Comprehensive The services provided as outlined by the compust- (ii) Be provided by quaccordance with each care. This REQUIREMENT by: Based on staff intervence and review the fact of care interventions for 1 of 5 residents (I unnecessary medical Preadmission Screen (PASRR) Level II for #86) reviewed for PAThe findings included 1. Resident #85 was	e Care Plans and or arranged by the facility, amprehensive care plan, ualified persons in the resident's written plan of This not met as evidenced view, physician interview, and cility failed to follow the plan related to seizure medication Resident #85) reviewed for tions and related to ning and Resident Review 1 of 1 residents (Resident ASRR. d: admitted to the facility on	F 2	F 282 1)The lab results for a K 9/14/17 for Resident # 8 by the physician on 10/2 orders. The lab results v filed in the resident s re reviewed by the physicia follow up for assuring lal drawn, received, reviewed orders carried out.	35 was reviewed 25/17 with no new were inadvertently ecord before being an and with no bs have been		
	1. Resident #85 was			drawn, received, review	ed, and any new red labs for		

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		345051	B. WING _		10/26/2017
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	•
				405 SOUTH GREENE STREET	
ANSON H	EALTH AND REHABII	LITATION		WADESBORO, NC 28170	
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F 282	Continued From page 2	age 13	F 2	282	
F 282	#85 indicated an of (anticonvulsant) 50 morning and 1000. The quarterly Minit assessment dated #85's cognition with included epilepsy. A physician's ord laboratory test for the plan of care from 10/24/17. The problem/need of maseful related to a interventions included a interventions included by the problem of the pro	visician 's orders for Resident rder dated 5/9/17 for Keppra 20 milligrams (mg) in the mg in the evening. mum Data Set (MDS) 8/19/17 indicated Resident as intact. His active diagnoses er dated 9/13/17 indicated a Resident #85 's Keppra level. ent #85 's medical record atory results related to the sorder for a Keppra level. er Resident #85 was reviewed plan of care included the conitoring Resident #85 's diagnosis of seizures. The ded, in part, obtaining ordered to monitor for evels of seizure medication and obysician of laboratory results. First initiated on 3/22/16 and ever noted. econducted with Unit Manager 17 at 4:30 PM. Resident #85 'nat contained no laboratory me 9/13/17 physician 's order was reviewed with UM #1. She ratory results were not in	F 2	Test Ordered Date Specimen Obtain Tech/Nurse Initial Date Report Received Check If Abnormal Date MD Notified New Order or No New Nurse Note: Family Notified An In-service was initiated of Nursing on 11/8/17 to 10 licensed nurses related to t they will follow once they re for a lab to be obtained. No work until they have receive in-service and this in-service included in new nurse orier	obtained as cility timely, imely and all at by the dit was ere were 22 initial audit of Nursing. All corrected by the Unit by the Regional 7/17 include: Room # and MD Response: Order by the Director 0% of all he process eceive an order arses will not end the ere will be intation.
	on 10/24/17 at 4:4	ew was conducted with UM #1 0 PM. She provided a copy of dated 9/14/17 for a Keppra		The Unit Manager will revie Monday through Friday x 2 twice weekly to include wee weeks, then monthly x 1 to	weeks, then ekends x 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345051 B. WIN			10	10/26/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
				405 SOUTH GREENE STREET			
ANSON H	EALTH AND REHABIL	ITATION		WADESBORO, NC 28170			
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F 282	Continued From pa	ge 14	F 2	282			
. 202	level for Resident # showed no indication Practitioner had revishe was not sure were not in Resider	85. These laboratory results on the physician or Nurse riewed them. UM #1 revealed hy these laboratory results at #85 's medical record.		weekends to assure all lab r been received, the physician notified of the results, and a were carried out. The Lab Diagnostic Log will	n has been ny new orders be turned in		
	10/25/17 at 10:26 Adated 9/13/17 for a was reviewed. The 9/14/17 for Resider reviewed with the previewed his record Nurse Practitioner (results of this Kepp Resident #85. He shimself and/or the Nordered laboratory these laboratory resported no concern Resident #85. An interview was conversing (DON) on a indicated she expect	conducted with the physician on M. The physician 's order Keppra level for Resident #85 laboratory results dated at #85 's Keppra level was hysician. The physician is and revealed he and/or the NP) had not received the ra level dated 9/14/17 for stated his expectation was for NP to receive the results of all tests. The physician reviewed sults dated 9/14/17 and his with the Keppra level for conducted with the Director of 10/26/17 at 8:27 AM. She conducted to the participant of the participant of the provision to be conducted of the physician of the participant of the participant of the physician of the physicia		to the Director of Nursing for weekly x 8, then monthly x 1 and concerns to ensure the practice is compliant with curcorrection. Any concerns with at the time of discovery and be re-educated. The Plan of will be revised as deemed not maintain Regulatory Compliant The Director of Nursing will initial the results of the Laboux 8 weeks, then monthly x 1 and/or concerns. The Director of Nursing will results of the Lab monitoring Quality Assurance Committed months for trends, concerns recommendations for any mind the process of t	r review I for trends facility Irrent Plan of Ill be corrected the staff will Correction ecessary to ance. review and monitoring tool for trends report the g tool to the ee monthly x 3 y, and		
	2. Resident #86 wa 11/28/16 with multip schizophrenia. A review of the med #86 was determined Preadmission Scree (PASRR), dated 5/2	ening Resident Review		the process. 2) A PASRR screening was NC Must with the appropriat for Resident # 86 by the Social 10/30/17 due to his Significated in the response was received on 1 NC Must to retain the reside PASRR number. The Social Worker was reerelated to Level 11 PASRR for Change in Condition by the	e paperwork cial Worker on ant Change in e care plan. A 0/30/17 from ent s existing ducated for Significant		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345051	B. WING _			10/	26/2017
	ROVIDER OR SUPPLIER EALTH AND REHABILIT	TATION		40	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTH GREENE STREET VADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	FULL PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 282	dated 8/10/17 for Reassessment indicate PASRR related to see The plan of care for on 10/25/17. Reside initiated on 11/28/16 PASRR. The interver "Notify PASRR if chassocial Worker (SW) responsible staff me An interview was con 10/25/17 at 4:30 PM responsible for the relevel II PASRS. Sithad a Level II PASR unaware of the require-evaluation to the I resident with a Level significant change in PASRR Authority was 's significant change in indicated the SW was referral to the PASRI with Level II status h condition. An interview was condition.	ata Set (MDS) assessment sident #86. This d Resident #86 had a Level II prious mental illness. Resident #86 was reviewed ent #86 had a plan of care, related to his Level II entions included, in part, ange in condition." The was indicated as the ember for this intervention. Inducted with the SW on she indicated she was responsibilities related to the confirmed Resident #86. R. She revealed she was rement for a referral for PASRR Authority for a II status following a condition. She stated the sent notified of Resident #86 in condition related to his enducted with the MDS Nurse PM. She indicated her quirement for a referral for PASRR Authority for a	F2	282	Clinical Manager on 11/1/17. This information will be included in the Social Worker orientation packet for new Social Work hires. A 100% audit of all residents with a PASRR Level II was completed on 10/31/17 by the Regional Clinical Manafor the past 6 months to assure no significant change of condition had occurred without notification to NC Musas the care plans indicates. No other resident with a Level II PASRR were not to have had a significant change in condition. The Regional Clinical Manager provide an in-service to the Social Worker and MDS Nurse on 11/1/17 on reporting a significant change in condition for any PASRR Level II resident to NC Must at time of the discovery of the significant change per the resident care plan. As Social Worker has resigned at the facil the new Social Worker will be educated on the process during orientation and prior to working the floor. The MDS nurse will update the care pland submit a Level II PASRR request to NC Must in the event a resident has a significant change in condition until the new Social Worker starts on 12/12/17 is educated on the requirements of a Level II PASRR by the Director of Nursupon hire. Utilizing a Significant Change of Condit PASRR Level II QI Audit Tool, the DON	al ager st oted the the ity, d ans o and ing	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345051	B. WING _	B. WING		0/26/2017	
	(EACH DEFICIENC	ATION ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 282 F 285 SS=D	was her expectation that plan of care interventions were followed as well as the regulations related to PASRR.			will review the MDS schedule of completed assessments weekly x 8 weeks, and then monthly x 1 to ensithat any significant change of cond assessment that was completed for PASRR Level II resident, that the Nurse or Social Worker has notified Must of the significant change as indicated on the resident care plan. The Director of Nursing will review initial the QI Audit tool weekly x 8, 1 monthly x 1 month for trends or contributed in the monitoring to the Quarter Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modificat the process.	sure dition or a MDS d NC n. v and then oncerns. the ality		
	pre-admission screer (PASARR) program upof this part to the manavoid duplicative test includes: (1) Incorporating the PASARR level II detended evaluation report into care planning, and traction (2) Referring all level	nate assessments with the hing and resident review ander Medicaid in subpart C timum extent practicable to ing and effort. Coordination recommendations from the remination and the PASARR a resident's assessment, ansitions of care. Il residents and all residents possible serious mental					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		10/26/2017
	ROVIDER OR SUPPLIER EALTH AND REHABILI	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 285	(k) Preadmission Somental disorder and disability. (1) A nursing facility January 1, 1989, an (i) Mental disorder a (i) of this section, un authority has determindependent physical performed by a personal state mental health (A) That, because of condition of the individual reservices, whether the specialized services (ii) Intellectual disability authority has determined (A) That, because of condition of the individual reservices. (ii) Intellectual disability authority has determined (A) That, because of condition of the individual reservices and (B) If the individual reservices and	resident review upon a status assessment. reening for individuals with a individuals with intellectual must not admit, on or after y new residents with: s defined in paragraph (k)(3) less the State mental health nined, based on an all and mental evaluation on or entity other than the authority, prior to admission, of the physical and mental vidual, the individual requires provided by a nursing facility; equires such level of e individual requires; or	F 28		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	,	
		345051	B. WING _		10/26/201	7
	ROVIDER OR SUPPLIER	ATION		STREET ADDRESS, CITY, STATE, ZIP CO 405 SOUTH GREENE STREET WADESBORO, NC 28170	•	
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLIE APPROPRIATE	.ETION
F 285	(2) Exceptions. For post (i) The preadmission is paragraph(k)(1) of this for determinations in to a nursing facility of being admitted to the transferred for care in (ii) The State may charpeadmission screen paragraph (k)(1) of the to a nursing facility of (A) Who is admitted thospital after receiving hospital, (B) Who requires nur condition for which the hospital, and (C) Whose attending before admission to the is likely to require less facility services. (3) Definition. For put (ii) An individual is contained to the service of the servic	for intellectual disability. urposes of this section- screening program under is section need not provide the case of the readmission f an individual who, after e nursing facility, was n a hospital. oose not to apply the ing program under nis section to the admission	F2			
	disorder defined in 48 (ii) An individual is co intellectual disability i	33.102(b)(1).				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345051 B. WING			10/26/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	•	0.0.0.0
ANCONTI	FALTILAND DELIADULT	ATION		405 SOUTH GREENE STREET		
ANSON H	EALTH AND REHABILIT	ATION		WADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 285	Continued From page or is a person with a described in 435.101	related condition as 0 of this chapter.	F 2	85		
	mental health authori disability authority, as significant change in condition of a resider intellectual disability for This REQUIREMENT by: Based on staff interviacility failed to make after a significant chas sampled residents (Repreadmission Screen II status. The findings included Resident #86 was ad 11/28/16 with multiple schizophrenia. A review of the medical #86 was determined Preadmission Screen (PASRR), dated 5/25 Further record review change Minimum Data dated 8/10/17 for Resident 8/10/17 for Resident 8/10/17. Residentiated on 11/28/17. Residentiated on 11/28/16,	s applicable, promptly after a the mental or physical at who has mental illness or for resident review. T is not met as evidenced riew and record review the a referral for re-evaluation ange in condition, for 1 of 1 resident #86) reviewed for a resident Review Level riem in the diagnoses that included real record revealed Resident to have a Level II ring Resident Review //17. The revealed a significant resident #86. This revealed a significant resident #86 had a Level II ring Resident #86 had a Level II ring Resident #86 had a plan of care, related to his Level II		F 285 A PASRR screening was sub Must with the appropriate pa Resident # 86 by the Social \(\) 10/30/17 due to his Significal Condition as indicated in the response was received on 10 NC Must to retain the resider PASRR number. The Social Worker was re-edrelated to Level 11 PASRR for Change in Condition by the FC Clinical Manager on 11/1/17. information will be included in Worker orientation packet for Work hires. A 100% audit of all residents PASRR Level II was complet 10/31/17 by the Regional Clinfor the past 6 months to assusignificant change of condition occurred without notification as the care plans indicates. No resident with a Level II PASR	perwork for Worker on Int Change in Int Chan	
	PASRR. The interve	related to his Level II ntions included, in part, nge in condition." The		as the care plans indicates. No resident with a Level II PASR to have had a significant cha	RR were noted	

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		345051	B. WING _	B. WING		10/	/26/2017
NAME OF P	ROVIDER OR SUPPLIER		·	STREET	TADDRESS, CITY, STATE, ZIP CODE	•	
имом п	EALTH AND REHABILIT	ATION		405 SO	UTH GREENE STREET		
ANSON II	EALITIAND RETABILIT	ATION		WADE	SBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 285	An interview was con 10/25/17 at 4:30 PM. responsible for the received II PASRRs. Shad a Level II PASRR was unaware of the re-evaluation to the Fresident with a Level significant change in PASRR Authority was 's significant change 8/10/17 MDS. An interview was con on 10/25/17 at 4:30 Fawareness of the requestion to the Fresident with a Level significant change in reported the SW was referral to the PASRR with Level II status has condition. An interview was con Nursing on 10/26/17 was her expectation to PASRR were follow the responsibility of the service of the service of the responsibility of the service of the service of the responsibility of the service	was indicated as the inber for this intervention. Iducted with the SW on She indicated she was esponsibilities related to be confirmed Resident #86 R. The SW revealed she requirement for a referral for PASRR Authority for a status following a condition. She stated the sonot notified of Resident #86 in condition related to his should with the MDS Nurse PM. She indicated her suirement for a referral for PASRR Authority for a status following a condition. The MDS Nurse responsible for making a R Authority when a resident and a significant change in should be she she she indicated it was the SW to make a referral for PASRR Authority for a she she SW to make a referral for PASRR Authority for a she she SW to make a referral for PASRR Authority for a she SW to make a referral for PASRR Authority for a she SW to make a referral for PASRR Authority for a she status following a	F 2	The an ME sig PA tim character or in the sig new is a Lew upon the sig new that asset PA Nu Mu ind	ndition. e Regional Clinical Manager providin-service to the Social Worker and S Nurse on 11/1/17 on reporting a unificant change in condition for an user Level II resident to NC Must be of the discovery of the significant ange per the resident care plan. the Social Worker has resigned as cility, the new Social Worker will be ucated on the process during entation and prior to working the flee MDS nurse will update the care disubmit a Level II PASRR requests as Must in the event a resident has unificant change in condition until the wide Social Worker starts on 12/12/11 educated on the requirements of a vel II PASRR by the Director of Nurson hire. Elizing a Significant Change of Contustrial Significant change of conditions as seeks, and then monthly x 1 to ensure at any significant change of conditions as the seeks, and then monthly x 1 to ensure at any significant change of conditions as seeks, and then monthly x 1 to ensure at any significant change of conditions as the seeks and the monthly x 1 to ensure at any significant change of conditions as the seeks and the monthly x 1 to ensure at any significant change of conditions as the seeks and the monthly x 1 to ensure at any significant change of conditions as the seeks and the monthly x 1 to ensure at any significant change of conditions as the seeks and the resident, that the ME was completed for a seeks and the resident care plan.	d a b a b y at the t t t the cor. colans t to a ne 7 and rsing dition DN re con a DS NC	
				mo	tial the QI Audit tool weekly x 8, the onthly x 1 month for trends or conce Director of Nursing will report the	erns.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345051	B. WING		10/26	6/2017
	ROVIDER OR SUPPLIER EALTH AND REHABILIT.	ATION	•	STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 285	Continued From page	e 21	F 28	results of the monitoring to the Assurance Committee monthly months for trends, concerns, a recommendations for any moduthe process.	/ x 3 and	
F 315 SS=D	BLADDER CFR(s): 483.25(e)(1) (e) Incontinence. (1) The facility must econtinent of bladder areceives services and continence unless his or becomes such that to maintain. (2)For a resident with on the resident's comfacility must ensure the indwelling catheter is resident's clinical concatheterization was not indwelling catheter or is assessed for remo as possible unless the demonstrates that catheterizes appropriate	ensure that resident who is and bowel on admission diassistance to maintain is or her clinical condition is to continence is not possible a urinary incontinence, based aprehensive assessment, the nat- ters the facility without an not catheterized unless the idition demonstrates that	F 31	5	1	1/17/17

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		10/26/2017	
	ROVIDER OR SUPPLIER EALTH AND REHABILI	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170	10.20.20 11	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 315	on the resident's co facility must ensure incontinent of bowe treatment and servibowel function as properties of the facility	ith fecal incontinence, based imprehensive assessment, the start a resident who is a receives appropriate ces to restore as much normal possible. It is not met as evidenced eview, observations, resident, RP), staff and physician the failed to follow through with a propointment on 9/08/17 for 1 dent #51) who had a history of ins. This resulted in a missed end year and the resident was an days later with diagnoses of a tract infection. The findings indicated 4/03/17 with the sof benign prostate and urinary retention.	F 31	F315 The admitting nurse did not use the discharge packet from the hospital tha arrived with the resident to do the resident s readmission orders. She use the referral discharge summary prior to the resident s readmission to complete the resident s readmission orders. The discharge packet had been update with the Urology Consult information, but the referral discharge summary did not have the Urology Consult Information included, causing the urology appoint information to be missed on readmission 8/30/17. A second check of the order was not completed on the admission orders. Resident #51 was seen by the Urologic on 10/27/17 new orders were received and carried out. A 100% audit of residents admitted or re-admitted residents in the past 30 dat to assure all recommended follow up appointments/consults were ordered a	sed ore ed out t nent on ers	
	Urology was consul catheter was placed read that Resident	ted and an indwelling urinary I. The discharge summary #51 was to have a follow up e Urologist on 9/08/17 at		scheduled was completed by the Regice Clinical Managers x 2. There were a total of 5		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051 B. WING					
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	•	10/26/2017	
				405 SOUTH GREENE STREET			
ANSON H	EALTH AND REHABILIT	ATION		WADESBORO, NC 28170			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 315	Continued From pag	e 23	F 31	5			
	10:00 AM. A review of Resident on 8/30/17 included a	#51's re-admission orders antibiotic therapy of Cefdinir by mouth every twelve hours		admissions/readmissions revie There was one noted issue re omitted orders during the audi missed order was addressed audit by the Regional Clinical	lated to t. The during the		
	Resident #51 was ca catheter on 8/30/17 s uropathy. Interventio assessment of the co his urine along with r UTI and for urinary c	re planned for his urinary secondary to obstructive		The Director of Nursing initiate in-service to 100% of licensed 11/9/17 to use the final Discha Summary for writing admission with special attention to recomfollow up appointments/consult A second nurse must review of the final Discharge Summary is that the order was transaction.	nurses on arge or orders on orders orders. orders with and verify		
	schedule did not incl scheduled Urology a A nursing note dated RP stated Resident a voided. The nurse as temperature was 99.	ember 2017 transportation ude Resident #51's ppointment for 9/08/17. 9/13/17 at 6:50 PM read the #51 was "hot" and had not esessed Resident #51. His 6 degrees Fahrenheit and was noted to have a small		that the orders were transcribed with special attention to recomfollow up appointments/consult newly hired nurses will receive education during orientation poworking the floor. The in-service completed on 11/17/17. Utilizing a Consult QI Audit Township and Consult QI Audit T	nmend Its. All e the rior to ce was		
	physician was notifie for Intravenous fluids antibiotic therapy and	in the tubing. The facility d and orders were obtained (IV), continue his ongoing d to get a chest -x-ray.		admission/re-admission final I Summaries to assure recomm follow up appointments/consul ordered and scheduled.	lended Its were		
	Resident #51 was let was patent draining of antibiotics were start. A nursing note dated Resident #51 was set unresponsiveness.	9/14/17 at 2:40 PM read chargic, his urinary catheter cloudy yellow urine. IV ed for a left lung infiltrate. 9/15/17 at 10:13 AM read ent to the ER due to tal discharge summary dated		Monitoring will occur within the the admission date to ensure recommended follow up appointments/consults were s All admissions x 3 months will using the consult QI Audit Too Director of Nursing will review the audits tools weekly x 3 mo	cheduled. be audited I. The and initial		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345051	B. WING		10/26/2017		
	ROVIDER OR SUPPLIER EALTH AND REHABILI	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170			
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
F 315	9/19/17 indicated Ri sepsis, encephalopa acute kidney injury, UTI associated with tract. He was to folke physician within 4-6 Resident #51 was on 10/24/17 at 4:25 PN wheelchair with his urinary catheter tubin urine. Resident #51 indicated he was material to see the Urologist declined an observatore. In an interview on 1 Social Worker (SW) nurses' responsibilitiany post hospitalization she called the Urologist Resident #51 did not scheduled on 9/8/17 appointment scheduled on 9/8/17 appointment scheduled in an interview on 1 Manager (UM) #1 st Resident #51's re-air 8/30/17. She stated a copy of the urolog for the transport per the next day. UM #1 readmitted during of nurse makes a copy appointments and the transporter. Additio medical records per the transporter persistence in the second person of the transporter person the transporter person of the transporter person the transporter person of the transporter person	esident #51 was admitted with athy (abnormal brain function) BPH, urinary retention and a catheterization of the urinary ow up with his primary care days. bserved and interviewed on the was sitting up in his RP present in his room. His ng contained cloudy yellow voiced no discomfort and ade aware of an appointment on 10/27/17. Resident #51 ation of his urinary catheter 0/25/17 at 12:10 PM, the stated it was the readmitting y to set up transportation for tion appointments. She stated gist and they noted that at show up for his appointment on 10/27/17. 0/25/17 at 12:20 PM, Unit that and Nurse #4 completed dmission from the hospital on Nurse #4 should have made y appointment card and left it son to set up transportation stated when a resident was effice hours, the admitting	F 315	The Director of Nursing will report results of the monitoring at monthl Quality Assurance Quality Improve (QAPI) Committee meeting X 3 m for trends and recommendations for modification of the process.	y ement onths		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345051	B. WING			10/	26/2017
	ROVIDER OR SUPPLIER EALTH AND REHABILITA	ATION		40	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTH GREENE STREET VADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315	late on a Wednesday have been left for the In an interview on 10. Director of Nursing (Expectation that Resi attended his schedule appointment on 9/8/1 problems with his cat to his intended appoint readmitted to the hos In a telephone intervithe physician stated Resident #51 to have on 9/8/17 as schedule was missed, he would to have rescheduled earliest date the Urold The physician stated with the DON regardi in September and reconstruction DRUG REGIMEN IS UNNECESSARY DR CFR(s): 483.45(d) Unnecessary drugs. drug when used	esident #51 was readmitted night, a copy would only transport person. (25/17 at 1:43 PM, the DON) stated it was her dent #51 would have ed follow up urology 7 because he was having heter in the days leading up interest and ended up being pital on 9/15/17. ew on 10/26/17 at 8:51 AM, he would have expected ed and if the appointment do have expected the facility the appointment for the pogist could have seen him. The would be following up ing his missed appointment cent re-hospitalization. FREE FROM UGS (1)-(2) ary Drugs-General. regimen must be free from An unnecessary drug is any et (including duplicate drug)		315			11/17/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WING _			10/	26/2017
	ROVIDER OR SUPPLIER EALTH AND REHABILIT	ATION		STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From pag	e 26	F:	329			
	(4) Without adequate	e indications for its use; or					
		f adverse consequences ase should be reduced or					
		s of the reasons stated in rough (5) of this section.					
	483.45(e) Psychotrop Based on a compreh resident, the facility r	ensive assessment of a					
	drugs are not given t medication is necess	ave not used psychotropic hese drugs unless the eary to treat a specific ed and documented in the					
	gradual dose reduction interventions, unless an effort to discontinuthis REQUIREMENT by: Based on record revand staff interview, the	clinically contraindicated, in			F329 1) The Physician was notified of the		
	(Resident #71) and for dose reduction (GDR medication (Resident residents reviewed for Findings included:	ailed to attempt a gradual R) for an antidepressant t # 85) for 2 of 5 sampled or unnecessary medications.			duplicate antibiotic therapy for Resider #71 on 10/24/17 by the Unit Manager a orders were received to discontinue Augmentin at that time. The resident completed the course of Doxycycline of 10/29/17 as ordered. The duplication orders was due to failure of the staff to	and on of	
	1. Resident #71 was	admitted to the facility on		- 1	notify the physician of the previously		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345051	B. WING		10/2	10/26/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	0/2017	
				405 SOUTH GREENE STREET			
ANSON H	EALTH AND REHABILIT	ATION		WADESBORO, NC 28170			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 329	Continued From page	e 27	F 32	9			
	11/5/12 with multiple	diagnoses including stage 4		ordered antibiotic.			
	sacral pressure ulcer	. The quarterly Minimum					
		essment dated 9/7/17		The Regional Clinical Manag			
		ent #71's cognition was intact		an in-service to the Unit Man	•		
	and she had a stage	4 pressure ulcer.		Director of Nursing on duplic			
	0 40/0/47 D : 1			medication therapy on 11/01			
	· ·	t #71 had a doctor's order to		in-service of the nursing staf			
	culture the sacral pre	essure uicer.		11/01/17 by the Director of N documenting in the order the			
	The culture report da	ted 10/11/17 revealed "Gram		medications ordered by the			
	_ ·	ght growth of Group B		also reviewing to see if multi			
	streptococcus."	gitt growth or Group B		are being used, and reportir			
	'			duplication orders to the Phy	-		
		d care-specialist evaluation was reviewed. The form		in-service was completed on			
		ulture of stage 4 pressure		Licensed nursing staff will no			
		demonstrated a positive		floor until they have signed the			
		th of Group B streptococcus.		Newly hired licensed nurses			
	The form indicated a			the education during orientat			
		otic used to treat bacterial		On 10/30/17, the Unit Manag			
	· ·	gs 1 tablet by mouth twice a		100% audit of the Medication Administration Records for u	-		
	day for 7 days.			duplication of antibiotic medi	•		
	On 10/16/17 Reside	nt #71 had a doctor's order		ordered in the past 30 days.			
	for Augmentin 875-12	25 milligrams (mgs) 1 tablet ours for 7 days for wound		in-service was completed on			
	infection.	ca.c.o. / dayo for mound		No instances of duplicate the	erapy were		
				found. All newly hired licens			
	On 10/18/17, Reside	nt #71 had a doctor's order		receive the education during			
	for Doxycycline (antil	piotic used to treat bacterial		Licensed nursing staff will no	ot work the		
		tablet by mouth every 12		floor until they have signed the	he in-service.		
	hours for 10 days for	sacrai wound.		A Duplicate Antibiotic Marrite	ring Ol quelit		
	The Medication Admi	inistration Records (MARs)		A Duplicate Antibiotic Monito tool will be completed by the			
		re reviewed. The MARs		Manager Monday through Fr			
	revealed that Reside			weeks, then twice weekly x 6	•		
				include weekends, then twice			
	Augmentin on October 17, 18, 19, 20, 21 and 22 and Doxycycline on October 19, 20, 21, 22, 23			include the weekend x1 mon	,		
	and 24.			concerns will be corrected by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345051	B. WING _			10,	/26/2017
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				405	SOUTH GREENE STREET		
ANSON H	EALTH AND REHABILIT	IATION		WA	ADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 329	Continued From pag	ne 28	F 3	329	Manger as they are discovered. The		
	On 10/24/17 at 3:50 PM, the Family Nurse				Director of Nursing will review and initia	al	
		as interviewed. She stated			the weekly audits x 8 weeks, then mon		
	that she ordered the	Doxycycline for the sacral			x 1 for trends and concerns and adjust	the	
		negative bacilli culture report.			plan of correction as needed to ensure		
		she was not aware that			regulatory compliance.		
		ready on Augmentin for the			The Disease of November will appear at the		
	same purpose (sacral wound infection). She stated that she would discontinue the Augmentin as this was a duplicate antibiotic therapy.				The Director of Nursing will present the results of the monitoring at the monthly		
					Quality Assurance Performance		
	ao imo wao a aapiiot	ate difficite therapy.			Improvement (QAPI) Committee meeti	na	
	On 10/25/17 at 2:28	PM, the Director of Nursing			monthly for 3 months for review and		
		ed. The DON stated that			recommendations for any modification	of	
	she expected the nu	rses to clarify with the Nurse			the monitoring process.		
		vas a duplicate antibiotic					
		ndicated that she expected			2)Resident #85 s pharmacy		
		resident was already on an			recommendation of 8/23/17 for a gradu		
		ing another order for an			dose reduction of Lexapro was reviewed		
	antibiotic therapy.				by the Psychiatric Nurse Practitioner of 10/26/17. The Nurse Practitioner has	1	
					scheduled the resident for a full review	on	
					her next visit on 11/9/17 for dose	011	
					reduction. The error was due to the lac	k of	
	2. Resident #85 was	admitted to the facility on			oversight to assure recommendations		
	3/11/16 with diagnos	es that included major			were reviewed timely by the physician	and	
	depressive disorder.				Psychiatric Nurse Practitioner.		
	A review of Resident	t #85 's medical record			The Director of Nursing reviewed all		
		ated 9/16/16 for Lexapro			pharmacy consults for the months of		
		milligrams (mg) once daily.			August 2017 and September 2017. Th	е	
	, , ,				audit was completed on 10/31/17. Mult	iple	
	The quarterly Minim				recommendations were not completed		
		/19/17 indicated Resident			prior to the next pharmacy review. All		
	_	s intact. He had no mood			pharmacy recommendations that were		
		issues, and no rejection of			found not completed in the audit were		
		received antidepressant days during the MDS review			followed up on by the Director of Nursin	ıg	
	period.	uays during the MDS review			by 10/31/17.		
	periou.				On 10/24/17, the Regional Clinical		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WING_		1	0/26/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII		0.=0.=0.1	
ANCONIII	EALTH AND DEHABIL	ITATION		405 SOUTH GREENE STREET			
ANSON H	EALTH AND REHABIL	ITATION		WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	Continued From pa	ge 29	F 3	29			
F 329	A Consultant Pharm Physician form date recommendation fo (GDR) of Lexapro (mg) once daily for use the lowest effect response from the part A Consultant Pharm Physician form date recommendation for once daily for Reside lowest effective dos from the physician of A review of Resider and electronic Medi (eMAR) from April 2 revealed he received An interview was consulted that the recommendation of the DON added that the pharm November 2016 and recommendations of followed through. Stacility had no system consultant were resulted to the Precommendations of t	nacist Communication to ed 4/28/17 indicated a r a Gradual Dose Reduction antidepressant) 20 milligrams Resident #85 in an effort to ctive dose. There was no obysician on the form. nacist Communication to ed 8/23/17 indicated a repeat r a GDR of Lexapro 20 mg dent #85 in an effort to use the se. There was no response on the form. In the form. In the form the form the form the form the form the form the form. In the form the for	F3	Manager completed an in Director of Nursing and Upharmacy recommendation and follow up process. The Physician received an integer Regional Clinical Managet timely responses to phare recommendations, and the Nurse Practitioner receives by the Director of Nursing Utilizing a Pharmacy Real Audit Tool, the Unit Managethe pharmacy report more that all recommendations returned completed approphysician and Psychiatric Practitioner prior to the new review. The Director of Nand initial the QI Audit Total trends and concerns. The Director of Nursing Versults of the monitoring Quality Assurance Quality (QAPI) Committee meeting for review and recommendation of the process.	Unit Manager on ion completion The attending -service by the er on 10/31/17 on macy he Psychiatric yed the in-service g on 11/2/17. Commendation QI ager will review on the consure is have been copriately by the consure in the control of the cont		
	recommendations of by the Pharmacy C	·					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		10/26/2017	
	ROVIDER OR SUPPLIER EALTH AND REHABILITA	ATION		STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE.	
F 329 F 332 SS=D	She stated she started September 2017. She of the monthly drug red the previous Pharmacassumed the recommand 8/23/17 to attempresident #85 had been because there was no order. The Pharmacy the future, she would from the Physician, in recommendation was on the form. A follow up interview DON on 10/26/17 at 8 Resident #85 had been a year with no attempted cumented clinical rof a GDR. She stated GDRs to be completed FREE OF MEDICATIOR MORE CFR(s): 483.45(f)(1) (f) Medication Errors. that its- (1) Medication error regreater; This REQUIREMENT by: Based on observation pharmacist interviews facility failed to maintion less as evidenced.	t on 10/25/17 at 1:55 PM. d coming to facility in e indicated she had copies egimen review notes from cy Consultant. She nendations dated 4/28/17 of a GRD of Lexapro for en rejected by the Physician of change in the Lexapro Consultant added that in make sure the response including the rationale if the erejected, was documented was conducted with the 3:27 AM. She confirmed en on Lexapro 20mg for over	F 325			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345051	B. WING			0/26/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	•	0.10.10.11	
				405 SOUTH GREENE STREET			
ANSON H	EALTH AND REHABILITA	ATION		WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 332	Continued From page	e 31	F 3	32			
	of 7 residents observed pass. The findings income A review of the manual	facturer instructions read Do		tablet before administering the to the resident during the me observation. The nurse faile physician order completely opackage of the medication was a superior or the superior of the superio	edication pass ed to read the or the bullet where orders		
		Extended Release since it sion (low blood pressure).		were written to do not crush documented and did not follo rights of medication pass.			
	Resident #82 took all Nurse #3 pulled all th be administered at 8: Extended Release ta Isosorbide Extended antihypertensive with mechanism. A review administration record individual punch card	ident #82. Nurse #3 stated her medications crushed. e medications scheduled to 00 AM including Isosorbide blet 30 milligrams. Release is an		On 11/1/17, the Director of N initiated an in-service with al Medication that is labeled do shall not be crushed. A copy non-crushable meds was ince the in-service and posted in Narcotic book for each medi The in-service was complete 11/17/17. All current nurses serviced prior to working the hired nurses and Med Aides the education during oriental	Il Nurses on o not crush of of cluded with front of the cation cart. ed on will be in the hall. All newly will receive		
	Isosorbide into a plas crush all the medicati applesauce to aid Remedications. Once N the medications into tenter Resident #82's stopped Nurse #3 fromedications. Nurse # special instructions por the punch card and #82's 8:00 AM medithe Isosorbide without whole tablet in with thapplesauce and Resimedications without of	sident #82 in swallowing her urse #3 finished mixing all he applesauce and began to a room, this surveyor m administering the crushed 3 stated she did not see the rinted on the electronic MAR d re-prepared all Resident cations and separated out to crushing. She placed the ree other medications into the dent #82 swallowed the lifficulty. Nurse #3 stated		Beginning 11/13/17, the Unit Pharmacy Consultant, Director Regional Clinical Manage complete a medication pass licensed nursing staff over a include weekends by 12/1/11/11/29/17 no nurse will take a passing a medication pass a of 5% or less. Any concerns addressed at the time of the pass observation and the nureeducated. Medication pass audits will in #3 and #2. Any concerns will	t Manager, tor of Nursing, or will audit on all Il shifts to 7. Beginning a cart before audit at a rate will be medication urse will be nclude Nurse I be		
		what could happen to a dame an extended release		addressed at the time of the and re-education provided.			

OE: TE: T	O T OIT MEDIO, TILE &	WEDIO/ ND OLITATOLO					2. 0000 000 1
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345051	B. WING			10/	26/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
				40	05 SOUTH GREENE STREET		
ANSON H	EALTH AND REHABILITA	ATION			VADESBORO, NC 28170		
0411.1=	CLIMANA DV CT	TATEMENT OF DEFICIENCIES			 		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
F 332	Continued From page	e 32	F	332			
	medication crushed v		'	002	of Nursing will review and initial the		
		/25/17 at 10:25 AM, the			Medication Pass Audits as they occur	and	
		as his expectation the			QI for trends and concerns.	iliu	
		orbide Extended Release be			Quior trends and concerns.		
	administered whole a				The Director of Nursing will present the	7	
					results of the monitoring at the monthly		
	In a telephone intervi	ew on 10/25/17 at 2:05 PM,			Quality Assurance Performance		
	· ·	acist stated Isosorbide			Improvement (QAPI) Committee meeti	ng	
	•	nould be administered			monthly for 3 months for review and	J	
	crushed because it can result in a sudden drop in				recommendations for any modification	of	
Resident #82 's blood pressure.		d pressure.			the monitoring process.		
	2. On 10/25/17 at 10:			2)Resident #89 was provided Carafate			
	observed preparing n				and Duoneb nebulizer treatment by Nu	rse	
		ident #89. Carafate (treat			#3		
		al ulcers) one gram tablet			Medications were administered more to	nan	
		due at 7:30 AM and at 11:30			1 hour after the ordered administration		
		IAR indicated the 7:30 AM een administered and it was			time due to the failure of the nurse to		
	time for the 11:30 AM				notify the Unit Manager or Director of Nursing that she was becoming late in	hor	
		stered Duoneb 0.5 mg in 3			med pass.	Hei	
	milliliters using Resid	•			med pass.		
	nebulizer. A review of				On 11/8/17 the DON initiated an in-ser	vice	
		ng treatments were to be			with all nurses on timely medication		
		es daily and was due at 8:00			administration in having 1 hour before	and	
		00 noon and that the 8:00 AM			1 hour after to administer medications		
		dministered as of 10:55 AM.			to notify DON or Unit Manger if the nur	se	
	Nurse #3 stated she	was late with her medication			is running behind on medication pass.		
	-	rmed she did not report to			The in-service was completed on		
	_	he Director of Nursing			11/17/17. Staff will not work until they		
	` <i>'</i>	ate passing her morning			have received the in-service. New sta	Ť	
	medications.	105 (47 . 1 4 40 DM . 11 . DOM			will be in serviced regarding timely	•	
		/25/17 at 1:43 PM, the DON			medication administration prior to work	ıng	
		rated with three nurses			the floor.		
	passing medications daily and that she was not aware that Nurse #3 was late in passing her				Poginning 11/12/17 the Unit Menana		
		was late in passing ner . She stated it was her			Beginning 11/13/17, the Unit Manager, Pharmacy Consultant, Director of Nurs		
	expectation that Resi				or Regional Clinical Manager will	ıııg,	
					complete a medication pass audit on a	II	
	medications within one hour before or		1		John proto a modroditori paggi addit off a	**	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WING_			10/	26/2017	
	ROVIDER OR SUPPLIER EALTH AND REHABILITA	ATION		STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	SANITARY CFR(s): 483.60(i)(1)-(i)(1) - Procure food fit considered satisfacto authorities. (i) This may include for	TORE/PREPARE/SERVE - (3) rom sources approved or ry by federal, state or local cod items obtained directly		3332	licensed nursing staff over all shifts to include weekends by 12/1/17. Beginnir 11/29/17 no nurse will take a cart befor passing a medication pass audit at a ra of 5% or less. Any concerns will be addressed at the time of the medication pass observation and the nurse will be reeducated. Medication pass audits will include Nur #3 and #2. Any concerns will be addressed at the time of the observation and re-education provided. The Director of Nursing will review and initial the Medication Pass Audits as they occur at QI for trends and concerns. The Director of Nursing will present the results of the monitoring at the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting monthly for 3 months for review and recommendations for any modification the monitoring process.	e e e e e e e e e e e e e e e e e e e	11/17/17	
	and local laws or regulation (ii) This provision doe	subject to applicable State ulations. s not prohibit or prevent roduce grown in facility						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X*		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345051	B. WING _			10/26/2017	
	ROVIDER OR SUPPLIER EALTH AND REHABILIT	ATION		STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170	•		
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F 371	safe growing and food (iii) This provision do from consuming food (i)(2) - Store, prepare accordance with profeservice safety. (i)(3) Have a policy resolution foods brought to resilivisitors to ensure saft handling, and consumantial resolution foods brought to resilivisitors to ensure saft handling, and consumantial resolution foods brought to resilivisitors to ensure saft handling, and consumantial resolution foods brought to resilivisitors to ensure saft handling, and consumantial resolution foods and the food food foods are spiration food foods and expiration date of A bottle of Glucernal used by date 10/1/17 On 10/25/17 at 3:50 (DM) was interviewe	ompliance with applicable id-handling practices. es not preclude residents is not procured by the facility. e, distribute and serve food in ressional standards for food egarding use and storage of dents by family and other e and sanitary storage, mption. T is not met as evidenced riew, observation and staff failed to discard expired ry product from 1 of 3 ators observed (Sunflower ed: PM, the Sunflower as observed. The log igerator was reviewed. The log igerator was checked on ng were observed inside the ator: theese - deli style slices with 9/30/17 shake - rich chocolate with a recommend. The DM stated that she	F3	F 371 On 10/25/17, the Certified Die Manager removed a can of GI a package of cheese from the on the Sunflower unit. The Re Clinical Manger checked the onourishment refrigerators for u expired foods with no negative. The facility failed to remove exfrom the refrigerator due the fadietary staff to monitor the refridaily for expired foods. On 10/27/17, the Regional Clin Manager re-educated the Diet Manager on the Food Receivin Storage Policy. The Dietary Minitiated 100 % re-education w staff. The in-service will be con 11/3/17. The Dietary will education will be con 11/3/17.	ucerna and refrigerator gional other undated or e findings. spired foods ailure of the rigerator unical early ng and eanager with Dietary mpleted by ate new staff		
	(DM) was interviewe was responsible for o			I	ate new staff I Receiving		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WING _			10/	/26/2017
	ROVIDER OR SUPPLIER EALTH AND REHABILITA	ATION	'	STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	that she had checked morning (10/25/17) a check the expiration of On 10/25/17 at 4:18 If (DON) was interviewed expected the dietary state.	expired food. She indicated I the nourishment rooms this and she might have missed to dates. PM, the Director of Nursing ed. She stated that she staff to check for expiration ment and dairy products that	F	371	in-service will not be allowed to work unin-service has been completed. All new hired dietary staff will receive the education by the Certified Dietary Manaduring orientation. Utilizing a Refrigerated Storage Audit Of Tool, the Scheduler or the Manager on Duty will complete a nourishment refrigerator audit Monday through Frida 2 weeks, then twice weekly to include weekends x 6 weeks, then monthly 1 month. Any negative findings will be corrected immediately by the Schedule Manager on Duty. The Administrator will review and initial the QI Audit tool weekly x 8 weeks, the monthly x 1 month for trends and concerns. The Administrator will present the results of the monitoring at the monthly QI committee meeting x 3 months for trends or concerns, the need for continued monitoring, and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and recommendation for any modification of the monitoring and review and r	ger QI ay x r or n nt	
	reviewed at least onc pharmacist. (3) A psychotropic dru	N (3)-(5)	F	428	the monitoring process.		11/17/17

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345051	B. WING _			0/26/2017	
	ROVIDER OR SUPPLIER EALTH AND REHABILIT.	ATION	•	STREET ADDRESS, CITY, STATE, ZIP COL 405 SOUTH GREENE STREET WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 428		e 36 drugs include, but are not e following categories:	F 4	28			
	(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist meto the attending physicallity's medical director and these reports much drug that meets the condition of this section for the during this review museparate, written reports attending physician and director and director and director and minimum, the resider	nust report any irregularities ician and the ctor and director of nursing, ast be acted upon. de, but are not limited to, any criteria set forth in paragraph an unnecessary drug.					
	resident's medical re- irregularity has been action has been take be no change in the r	ysician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending tument his or her rationale in all record.					
	and procedures for the review that include, be frames for the difference.	develop and maintain policies ne monthly drug regimen out are not limited to, time nt steps in the process and must take when he or she					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		10/26/2017	
	ROVIDER OR SUPPLIER EALTH AND REHABILIT	TATION	STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170		, .0.20.20	
(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 SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 428	identifies an irregula to protect the resident This REQUIREMEN' by: Based on record revent Pharmacist, Psychia staff interviews, the formultiple recommend Pharmacy Consultar residents reviewed for (Residents #71 & #8) Findings included: 1 a. Resident #71 was 11/5/12 with multiple insomnia. The quarter (MDS) assessment of Resident #71's cogning received an antideprolast 7 days. Resident #71's current reviewed. The order had an order for Reriappetite stimulant) 1 at bedtime for sleep/ Resident #71's drug reviewed. The DRR recommended for a formulation (GDR) for the Remerecommended for the Resident #71's elect Administration Recommended.	rity that requires urgent action nt. T is not met as evidenced view and Physician, trist, Nurse Practitioners and facility failed to act upon ations made by the nt for 2 of 5 sampled or unnecessary medications 5). as admitted to the facility on diagnoses including erly Minimum Data Set dated 9/7/17 indicated that ition was intact and she had ressant medication during the ent physician's orders were as revealed that Resident #71 meron (an antidepressant and 5 milligrams (mgs) by mouth rappetite. regimen reviews (DRR) were dated 5/24/17 had gradual dose reduction ron.	F 428	Resident #71 and 85 pharmacy recommendations were reviewed wi attending physician on 10/27/17 and Psychiatric Nurse Practitioner on 10 respectively. New orders received we carried out. The pharmacy recommendations were not reviewed timely due to lack of oversight to assall recommendations were reviewed returned for processing in a timely manner. The Director of Nursing reviewed all pharmacy consults for the months of August 2017 and September 2017. audit was completed on 10/31/17. We recommendations were not completed prior to the next pharmacy review. A pharmacy recommendations that we found not completed in the audit we followed up on by the Director of Nurby 10/31/17. On 10/24/17, the Regional Clinical Manager completed an in-service wide Director of Nursing and Unit Manage pharmacy recommendation completed and follow up process. The attending Physician received an in-service by Regional Clinical Manager on 10/31 timely responses to pharmacy	If the //26/17 rere d sure and f The lultiple ed	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345051	B. WING_			10/	/26/2017
ANSON H	ROVIDER OR SUPPLIER EALTH AND REHABILITA			40	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTH GREENE STREET VADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	(DON) was interviewed recommendations may consultant were given the Physician to be act that today (10/24/17) pharmacy recommen 2016 and realized that not been consistently acknowledged that the place to make sure the by the pharmacy constituent of the Physician or by N that as of today (10/2 Assurance (QA) plant, for monitoring the reserecommendations. The was no evidence that upon the recommend by the Pharmacy Consultant was intervent of the property of their response on the Communication form. On 10/25/17 at 10:26 Physician was interviend the recommendation form.	PM, the Director of Nursing and. She stated that the ade by the Pharmacy in to the unit manager and to ceed upon. The DON added she had reviewed the dations since November at the recommendations had followed through. She is a facility had no system in the recommendations made sultant were responded by ursing. The DON indicated 4/17) per their new Quality is she would be responsible ponses to the pharmacy in e DON indicated that there is the Physician had acted action dated 5/24/17 made is ultant for Resident #71. The facility's Nurse riewed. She stated that she is to be acted upon by the acted upon the acted upon the acted upon dated 5/24/17 by Consultant Pharmacist AM, Resident #71's ewed. He stated that he had endation dated 5/24/17 by Consultant for Resident if the recommendation was opic medication, the responsible to respond to	F	428	by the Director of Nursing on 11/2/17. Utilizing a Pharmacy Recommendation Audit Tool, the Director of Nursing will review the pharmacy report monthly to ensure that all recommendations have been completed appropriately by the physician and Psychiatric Nurse Practitioner prior to the next pharmacy review. The Director of Nursing will review and initial the QI Audit Tool mon x 3 for trends and concerns. The Director of Nursing will report the results of the monitoring at monthly Quality Assurance Quality Improvement (QAPI) Committee meeting X 3 months for review and recommendations for an modification of the process.	ithly at	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		10/26/2017	
	ROVIDER OR SUPPLIER EALTH AND REHABIL	ITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170		,	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 428	Consultant was intestarted coming to faindicated that she in regimen review not Pharmacist and she recommendation don Remeron was rebecause there was order. The Pharmashe would make su Physician was doct if the recommendation on 10/25/17 at 3:10 interviewed. She sto facility 6 months had not seen the remade by the Pharm #71. On 10/25/17 at 3:50 Practitioner (FNP) that she had not see 5/24/17 made by the Resident #71. On 10/2517 at 5:05 Practitioner was intended and the repharmacy Consultation in the resident #71.	5 PM, the Pharmacy erviewed. She stated that she acility in September 2017. She had copies of the monthly drug es from the previous e assumed that the lated 5/24/17 to attempt a GRD ejected by the Physician no change in the Remeron hacist added that in the future, are that the response from the lumented including the rationale tion was rejected. 6 PM, the Psychiatrist was tated that she started coming ago. She indicated that she ecommendation dated 5/24/17 hacy Consultant for Resident 6 PM, the Family Nurse was interviewed. She stated en the recommendation dated be Pharmacy Consultant for 6 PM, the Mental Health Nurse erviewed. She stated that she ecommendation made by the lant dated 5/24/17 for Resident	F 42	28		
	11/5/12 with multipl	s admitted to the facility on e diagnoses including terly Minimum Data Set				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	' '	ATE SURVEY OMPLETED
		345051	B. WING_			10/26/2017
	ROVIDER OR SUPPLIER EALTH AND REHABILI	TATION	STREET ADDRESS, CITY, STATE, ZIP CO 405 SOUTH GREENE STREET WADESBORO, NC 28170		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 428	Resident #71's cogreceived an antidepolast 7 days. Resident #71's currereviewed. The order had an order for Relappetite stimulant) 1 at bedtime for sleepolate H71's weign weight was 123 pour 137 lbs. on 3/2/17, amonths. Resident #71's drug reviewed. The Conscommunication to Frevealed that the resiloss of 18 lbs. over 9 Pharmacy Consultate consider changing Fistimulant) in an effort The form did not have physician. Resident #71's elected Administration Recognition of the consider than the considered had not have physician.	dated 9/7/17 indicated that dition was intact and she had ressant medication during the ent physician's orders were as revealed that Resident #71 meron (an antidepressant and 5 milligrams (mgs) by mouth /appetite. This were reviewed. Her mads (lbs.) on 7/19/17 and was a 14 lbs. weight loss over 4 Tregimen reviews (DRR) were cultant Pharmacist Physician form dated 7/25/17 sident had a significant weight of months period. The method recommended to Remeron to Marinol (appetite at to further increase appetite. We a response from the control Medication and (eMARs) from May 17 revealed that she had	F 4	,		
	(DON) was interview recommendations m Consultant were giv the Physician to be that today (10/24/17	PM, the Director of Nursing wed. She stated that the nade by the Pharmacy en to the unit manager and to acted upon. The DON added) she had reviewed the ndations since November				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		OATE SURVEY OMPLETED
		345051	B. WING			10/26/2017
	ROVIDER OR SUPPLIER EALTH AND REHABILI	TATION		STREET ADDRESS, CITY, STATE, Z 405 SOUTH GREENE STREET WADESBORO, NC 28170	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG	•	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 428	not been consistently acknowledged that to place to make sure to by the pharmacy control the Physician or by I that as of today (10/Assurance (QA) plant for monitoring the resecommendations. Towas no evidence the upon the recommendations to the Pharmacy Consultant was interexpected the recommendation form. On 10/25/17 at 10:2 Physician was interexpected the recommendation form. The added that regarding a psychotic psychiatric team was the recommendation. On 10/25/17 at 1:55 Consultant was interestanted coming to fain indicated that she have gimen review note the pharmacist and she interestanted she in the pharmacist and she interestanted coming to fain indicated that she have gimen review note the pharmacist and she interestanted coming to fain indicated that she have gimen review note the pharmacist and she interestanted coming to fain indicated that she have gimen review note the pharmacist and she interestanted coming to fain indicated that she have gimen review note that the pharmacist and she interestanted coming to fain indicated that she have gimen review note that the pharmacist and she interestanted coming to fain indicated that she have gimen review note that the pharmacist and she interestanted coming to fain indicated that she have gimen review note that the pharmacist and she interestanted coming to fain indicated that she have gimen review note that the pharmacist and she interestanted coming to fain indicated that she have gimen review note that the pharmacist and she interestanted coming to fain indicated that she have gimen review note that the pharmacist and she interestanted coming to fain indicated that she have gimen review note that the pharmacist and she interestanted coming to fain indicated that she have gimen review note that the pharmacist and she interestanted coming to fain indicated that she have gimen review note that the pharmacist and she interestanted coming to fain indicated that she have gimen review note that the pharmacist and she interestanted coming to fain indicated the	at the recommendations had y followed through. She he facility had no system in the recommendations made insultant were responded by Nursing. The DON indicated 24/17) per their new Quality in, she would be responsible sponses to the pharmacy. The DON indicated that there at the Physician had acted dation dated 7/25/17 made insultant for Resident #71. If the facility's Nurse eviewed. She stated that she mendations made by the into be acted upon by Physician and to document the Consultant Pharmacist in. If AM, Resident #71's riewed. He stated that he had inendation dated 7/25/17 acy Consultant for Resident if the recommendation was ropic medication, the is responsible to respond to in. PM, the Pharmacy viewed. She stated that she callity in September 2017. She ad copies of the monthly drug is from the previous	F	428		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED	
		345051	B. WING		1	0/26/2017	
	ROVIDER OR SUPPLIER EALTH AND REHABILITA	ATION		STREET ADDRESS, CITY, STATE, ZIP COI 405 SOUTH GREENE STREET WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 428	Remeron order. The the future, she would response from the Princluding their rational was rejected. On 10/25/17 at 3:16 I interviewed. She state to facility 6 months aghad not seen the recommade by the Pharma #71. On 10/25/17 at 3:50 I Practitioner (FNP) was that she had not seen 7/25/17 made by the Resident #71. On 10/2517 at 5:05 F Practitioner was internad not seen the recommade processive disorder. The quarterly Minimulassessment dated 8/ #85 's cognition was issues, no behavior is care. Resident #85 remarks and resident #85 remarks and resident #85 remarks and remark	was rejected by the lere was no change in the Pharmacist added that in make sure that the hysician was documented alle if the recommendation. PM, the Psychiatrist was ted that she started coming go. She indicated that she ommendation dated 7/25/17 cy Consultant for Resident. PM, the Family Nurse as interviewed. She stated in the recommendation dated Pharmacy Consultant for. PM, the Mental Health Nurse viewed. She stated that she ommendation made by the tradated 7/25/17 for Resident.	F 42	28			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345051	B. WING _			10/	26/2017
	ROVIDER OR SUPPLIER	ATION	•	40	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTH GREENE STREET VADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 428	Physician form dated recommendation for a	cist Communication to 4/28/17 indicated a a Gradual Dose Reduction	F	428			
	(mg) once daily for Ruse the lowest effecti response from the ph						
	Physician form dated recommendation for a (GDR) of Lexapro 20 #85 in an effort to use	cist Communication to 8/23/17 indicated a repeat a Gradual Dose Reduction mg once daily for Resident e the lowest effective dose. se from the physician on the					
	Administration Recor	#85 's electronic Mediation d (eMAR) from April 2017 to ed he was receiving Lexapro					
	(DON) was interviewed recommendations may consultant were give the Physician to be as she had reviewed the recommendations sin realized the recommendations sin realized the recommendations that act upon the recommendation act upon the recommendation of the recomme	ade by the Pharmacy In to the unit manager and to Interest the content of the con					
	Consultant was interv	PM, the facility's Nurse viewed. She stated she nendations made by the to be acted upon by					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
		345051	B. WING _	·····		10/26/2017
	ROVIDER OR SUPPLIER EALTH AND REHABILIT	TATION	•	STREET ADDRESS, CITY, STATE, ZIP CO. 405 SOUTH GREENE STREET WADESBORO, NC 28170	•	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 428	responses to be doc Pharmacist Commun On 10/25/17 at 10:26 Physician was intervient the recomment 8/23/17 made by the Resident #85. He adwas regarding a psychiatric team, incresponsible for responsible for	Physician and for their fumented on the Consultant nication form. AM, Resident #85's fewed. He stated he had not dations dated 4/28/17 or Pharmacy Consultant for dided if a recommendation chotropic medication, the luding the Psychiatrist, was onding. PM the Pharmacy viewed by phone. She oming to facility in September she had copies of the n review notes from the Consultant. She assumed as dated 4/28/17 and 8/23/17 Lexapro for Resident #85 of the Physician because in the Lexapro order. The at added that in the future, as the response from the	F 4	28		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345051	B. WING			10/	26/2017
	ROVIDER OR SUPPLIER	ATION		4	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTH GREENE STREET VADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428 F 431	for Resident #85.	e 45 dated 4/28/17 or 8/23/17 ABEL/STORE DRUGS &		428 431			11/17/17
SS=D	BIOLOGICALS CFR(s): 483.45(b)(2)((3)(g)(h)		4 31			
	drugs and biologicals them under an agree §483.70(g) of this par	t. The facility may permit to administer drugs if State under the general					
	that assure the accuration dispensing, and admi	cility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and ne needs of each resident.					
	(b) Service Consultati employ or obtain the s pharmacist who						
	disposition of all conti	em of records of receipt and rolled drugs in sufficient curate reconciliation; and					
	(3) Determines that d that an account of all maintained and period	•					
		s used in the facility must be e with currently accepted s, and include the y and cautionary					

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345051	B. WING _		_ 1	0/26/2017
	ROVIDER OR SUPPLIER EALTH AND REHABILIT	TATION	•	STREET ADDRESS, CITY, S 405 SOUTH GREENE STR WADESBORO, NC 281	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	the facility must storilocked compartment controls, and permit have access to the kind (2) The facility must permanently affixed controlled drugs listed Comprehensive Dru Control Act of 1976 abuse, except when package drug distrib quantity stored is milbe readily detected. This REQUIREMEN by: Based on observation facility failed to discarmedication carts (Rostore medications at specified by the marmedication rooms (Sincluded: 1. On 10/25/17 at 2 medication cart on Fill with Nurse #2. A via observed with an op discard date of 9/30/0 on the box that contact the bottle and did	and Biologicals. th State and Federal laws, e all drugs and biologicals in s under proper temperature only authorized personnel to keys. provide separately locked, compartments for storage of ed in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit aution systems in which the nimal and a missing dose can T is not met as evidenced ons and staff interviews, the ard expired insulin in 1 of 4 ose Avenue) and failed to the refrigerator temperature furfacturer in one of three sunflower). The findings and PM, an observation of the lose Avenue was conducted all of Humalog insulin was en date of 9/2/17 and a and T. The dates were written	F	F 431 1) On 10/25/17, the Resident #71 was medication cart by of insulin was replayed from the cart on 10 and the nurse put in the medication of the expiration date medication storage expired medication clinical Manger, U		

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345051	B. WING _		1	0/26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	•	
4 N/O O N/ 1/1	EALTH AND DELIABILIT	ATION		405 SOUTH GREENE STREET		
ANSON H	EALTH AND REHABILIT	ATION		WADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 431	Continued From page	e 47	F 4	31		
	indicated the insulin s	on the bottle. Nurse #2 should have been discarded the expiration date written		expired insulins or medic medication storage area facility. The audit was co 10/25/17.	s within the	
	conducted with Unit I insulin should have b	PM, an interview was Manager #1 who stated the een discarded on 9/30/17.		On 11/1/17, the Regiona provided an in-service to Nursing and Unit Manag Medication Storage Police	o the Director of ers on the cy. The Director of	
	2. On 10/25/17 at 2:20 PM, an observation was made of the Medication Room refrigerator on Sunflower. There was no thermometer in the refrigerator. The contents of the refrigerator at			Nursing initiated an in-se licensed nurses on 11/1/ medications for an expira administering. The in-se	17 to check ation date before	
	the time of the observ Latanoprost 0.005%	vation included, in part: three unopened vials (eye		completed 11/17/17. No be allowed to work until	licensed staff will they have	
	vaccine. The medical	njections of influenza tions were on a tray and bbserved on the plastic bags		completed the in-service will be incorporated into orientation packet. New	the nurse hires will receive	
				the education during orie 11/13/17.	entation Starting	
	Unit Manager #1 was Clerk was the person temperatures and the	PM, an interview with the sound of the Supply of the Supply of the Supply of the set temperature should be Fahrenheit and 46 degrees		The Unit Manager, Phar or Regional Clinical Con complete a Medication of 1 month, then monthly x ensure there are no explanation Storage area	sultant will art audit weekly x 2 months to ired medication in	
	included the following Store unopened bottl	facturer 's product atanoprost eye medication g storage requirements: e(s) under refrigeration at 2 s Celsius (36 degrees to 46		Any expired medication appropriately discard an reeducated as appropriately of Nursing.	found will be d staff will be	
		facturer 's product fluenza vaccine included the uirements: Store at 36		The Director of Nursing initial the Audit Tool wee weekends x 1 month, the include weekends x 2 m and concerns. The Directoresent the results of the monthly QI committee m	kly to include en monthly to onths for trends ctor of Nursing will e monitoring at the	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345051	B. WING		10/26/2017
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10.20.20.1
ANSON H	EALTH AND REHABILITA	ATION		405 SOUTH GREENE STREET	
ANOON	LALITI AND KLITADILITA	ATION .		WADESBORO, NC 28170	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDERSON CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 431	had been checking the temperatures since Justemperature in the reference of the second of the medication refrigered morning. She had resulted for the medication refrigered morning. She had resulted for the medication refrigered had forgotten to replass reviewed her monthly that the temperature is refrigerator was 41 deconstruction of the conducted on 10/25/11 a temperature of 50 deconstruction.	PM, an interview was upply Clerk. She stated she e medication refrigerator une 2017. She said the frigerator should be between it and 46 degrees ply Clerk stated the working when she checked erator on Sunflower this moved the thermometer and ce it. The Supply Clerk temperature log and noted in the Sunflower medication egrees on 10/24/17. PM, the Supply Clerk the supply Clerk in the medication wer. medication refrigerator was 7 at 3:33 PM and revealed tegrees. The Supply Clerk in sat that time and stated	F 43	months for trends and the need for continued monitoring. 2) On 10/25/17, the Maintenance I checked the refrigerator on Sunflor for proper working order with no coand replaced the thermometer. On 10/25/17 at 4:30pm, the temperaturechecked by Regional Clinical Mand the refrigerator was at 38 degron 10/25/17 the Regional Clinical Manager and Unit Coordinator che 100% of all medication refrigerator ensure all have thermometers and temperature was within an acceptal level. No concerns were noted at the time. The problem occurred as the Clerk failed to replace the thermon 10/25/17 after discovering it was nowrking. The temperature was not checked and the high temperature not corrected. On 11/1/17, the Regional Clinical Manager on the new temperature on all medication refrigerators on by the Unit Manager. The DON initian in-service to 100% of nursing signed Medication Storage and Refrigerat temperatures. The 7PM to 7AM shoursing staff will begin checking	Director wer hall oncerns i ure was anger rees. ecked es to the able hat e Supply neter on ot was Manager and ture posted 11/10/17 tiated taff on cor oift
				medication refrigerator temperature documenting the temperature on the beginning 11/12/17. The in-service completed by 11/17/17. No nursing will be allowed to work until they have received the in-service. All newly have	he log e was g staff ave

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345051	B. WING _			10/	26/2017
	ROVIDER OR SUPPLIER EALTH AND REHABILITA	ATION		40	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTH GREENE STREET /ADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	Continued From page			431	nurses will receive the education during orientation. Utilizing a Medication Refrigerator QI Audit Tool, the Unit Manager will complia medication refrigerator audit to ensur thermometer is in the refrigerator and the temperatures are within the 36 to 46 degree range. The Unit Manager will notify the Administrator and the Maintenance Director timely if the refrigerator temperatures are not in the acceptable range. Monitoring will be done twice weekly x month to include weekends then weekly a weeks to include weekends, then monthly x 1 month to include weekends. The Administrator will review the Audit Tool weekly x 8, then monthly x 1 for trends or concerns. The Administrator will review the results of the monitoring at monthly QI committee meeting x 3 months for trends or concerns, the neef or continued monitoring, and review and recommendation for any modification of the monitoring process.	ete e a he 1 y x s. will the d	
F 520 SS=D	QAA COMMITTEE-M QUARTERLY/PLANS CFR(s): 483.75(g)(1)	;	F !	520			11/17/17
	(g) Quality assessme(1) A facility must main and assurance community minimum of:(i) The director of numbers	ntain a quality assessment ittee consisting at a					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345051	B. WING		10/26/2017
	ROVIDER OR SUPPLIER EALTH AND REHABILIT	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170	,
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 520	Continued From pag	e 50	F 520		
		ctor or his/her designee;			
	staff, at least one of	, a board member or other			
	(g)(2) The quality assessment and assurance committee must :				
	coordinate and evalu	rterly and as needed to uate activities such as th respect to which quality surance activities are			
		lement appropriate plans of ntified quality deficiencies;			
	Secretary may not re records of such com such disclosure is re	ormation. A State or the equire disclosure of the mittee except in so far as lated to the compliance of the requirements of this			
	sanctions. This REQUIREMEN				
	nurse practitioner int interviews, the facilit Assurance (QAA) Co implemented proced	view, physician interview, terview, and facility staff y's Quality Assessment and committee failed to maintain tures and monitor the e committee put into place		F Tag 520 The facility will monitor and evaluate effectiveness of the identified QAPI programs by achieving and maintainin identified thresholds for F tags 278, 32	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345051	B. WING _			10/	26/2017	
NAME OF PR	ROVIDER OR SUPPLIER	•		STI	REET ADDRESS, CITY, STATE, ZIP CODE			
				405	5 SOUTH GREENE STREET			
ANSON H	EALTH AND REHABILIT	ATION		W	ADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 520	Continued From pag	e 51	F 5	520				
		5 and 10/20/16 recertification			282			
					202			
	surveys for 2 recited deficiencies in the areas assessment accuracy (F278) and unnecessary medications (F329), and following the 10/20/16 recertification survey for 1 recited deficiency in				F 278			
		•			The last Minimum Data Set (MDS)			
		rided by qualified persons in			assessment completed for resident #64	1		
	accordance with care	e plan (F282). These 3			was reviewed by MDS Coordinator on			
	deficiencies were cite	ed again on the current follow			10/25/17 and Section I was modified to			
	up recertification sur	vey of 10/26/17. The			include the diagnosis of Depression to			
	continued failure of t	he facility during 2 or more			accurately reflect the residents current			
		condition.						
	-	sustain an effective Quality						
		surance program. The			A 100% audit of the last completed MD			
	findings included:				assessment for all residents, to include			
					resident # 64, will be conducted by			
	This tag is cross refe	renced to:			Regional Reimbursement Managers (RRMs) to be completed by 11/17/17 to)		
		Accuracy: Based on record			ensure coding of the minimum data set			
		views, the facility failed to			accurately reflects the residents. No			
		ident #64 for the diagnosis of			errors were found in the diagnosis codi	ng		
	·	dmission Minimum Data Set			in section I of the MDS by 11/17/17.			
	(MDS) for 1 of 14 ML	OS assessments reviewed.			- "			
	Di	#:			For all areas of concern identified, a			
		tion survey of 11/19/15 the			modification or significant correction of			
		8 for failure to code the MDS as of medications and			prior assessment (Quarterly/Comprehensive) will be			
	•	uring the recertification			completed by the facility MDS Nurse by	,		
		ne facility was again cited			11/17/17.	<i>'</i>		
		de the MDS accurately in the			The MDS Nurse, Dietary Manager (DM)		
		e expectancy. On the current			and Activities Director (AD) will be	,,		
		of 10/26/17 the facility failed			re-in-serviced on proper coding of MDS	3		
	_	curately in the area of active			assessments per the Resident			
	diagnoses.	•			Assessment Instrument (RAI) Manual b	ру		
	_				the RRM to be completed by 11/17/17.	•		
		ed by Qualified Persons in			•			
		e Plan: Based on staff			When coding the MDS assessment the	:		
		nterview, and record review			MDS Nurses and Care Plan Team will			
	the facility failed to fo				follow the instructions for proper coding	1		
	interventions related	to seizure medication for 1			found in the Resident Assessment			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345051	B. WING _			10/	26/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				40	05 SOUTH GREENE STREET		
ANSON H	EALTH AND REHABILIT	ATION		V	ADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	unnecessary medica Preadmission Screer (PASRR) Level II for #86) reviewed for PADuring the recertificate facility was cited F28 of care for evaluation as needed for behaviors. On the cuto/26/17 the facility for care interventions reland PASRR Level II. 3. F329 - Unnecessare record review and Number interview, the facility free from duplicate at #71) and failed to attreduction (GDR) for a medication (Resident residents reviewed for During the recertificate facility was cited F32 non-pharmacological behaviors, failure to cause of behaviors etreatment with antips failure to reassess the for antipsychotic medical indication. Discreed the page 10/20/16 the F329 for failure to hall administration of an administration of a administra	ent #85) reviewed for tions and related to ning and Resident Review 1 of 1 residents (Resident SRR. tion survey of 10/20/16 the 2 for failure to follow the plan by a mental health provider fors to address assaultive rrent recertification survey of ailed to follow the plan of lated to seizure medications ary Medications: Based on larse Practitioner and staff failed to ensure resident was intibiotic therapy (Resident lempt a gradual dose an antidepressant to #85) for 2 of 5 sampled for unnecessary medications.	F	520	Instrument (RAI) Manual and ensure the the assessment accurately reflects the resident sourrent condition. An audit of 25% of completed Minimum Data Set (MDS) assessments will be conducted weekly x 4 weeks, then bi-weekly for 4 weeks, then 10% monthly x 1 month by RRM to ensure compliance and accurate utilizing a MDS audit Tool. All identified areas of concern will be addressed immediately by the RRM by retraining appropriate staff responsible for the coding error and by the MDS Nurse with modification or significant correction of MDS. The Administrator will review and initial the MDS Audit Tool weekly x 4 weeks, then bi-weekly x 4 weeks then monthly month. The results of the MDS Audit Towill be compiled by the Administrator and presented to the Quality Improvement Committee monthly x 3 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring. F 282 The lab results for a Keppra level of 9/14/17 for Resident # 85 was reviewed by the physician on 10/25/17 with no need for the resident second before be reviewed by the physician and with no follow up for assuring labs have been drawn, received, reviewed, and any need for every the physician on the province of the province of the province of the physician and with no follow up for assuring labs have been drawn, received, reviewed, and any need to the province of the province of the province of the physician and province of the prov	of / Ccy h the x 1 ool nd dew ntlly ing	
	administration of an a On the current recert the facility failed to el	antipsychotic medication.			follow up for assuring labs have been	w	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	` ′	E SURVEY PLETED	
		345051	B. WING			10	/26/2017	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
				40	05 SOUTH GREENE STREET			
ANSON H	EALTH AND REHABILITA	ATION		w	VADESBORO, NC 28170			
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F 520	Continued From page	e 53	F	520				
	GDR for an antidepre	essant medication.			A 100% audit of all ordered labs for			
	'				10/10/17 through 11/10/17 were review	ved		
	An interview was con	ducted with the			by the Director of Nursing (DON) to			
	Administrator on 10/2				assure all lab results were obtained as	i		
	indicated he was the	head of the facility 's QAA			ordered, received in the facility timely,			
		ed the QAA Committee			reviewed by the physician timely and a	all		
		self, the Director of Nursing,			new orders were carried out by the			
	MDS Coordinator, Ur	•			licensed nurse. The lab audit was			
		ions/Marketing Director,			completed on 11/10/17. There were 22			
	Dietary Manager, So	on Manager, Business Office			identified concerns with the initial audi			
	· ·	ntal Services, Maintenance			completed by the Director of Nursing. concerns were addressed/corrected by			
	_	cords, Medical Director, and			the Director of Nursing and the Unit	y		
	· ·	t. He reported he began			Manger by 11/10/17.			
	-	at the end of April 2017 and			manger by 11/10/11/			
		d implemented monthly QAA			A new lab log was created by the Regi	onal		
	meetings.	, , , , , , , , , , , , , , , , , , , ,			Clinical Consultant on 11/17/17 include			
	The Administrator ind	licated he was aware F278,			Patient Name" Room #			
	F282, and F329 were	repeat citations. He stated			Test Ordered			
		the facility at the time of the			Date Specimen Obtained			
	•	on surveys and was not			Tech/Nurse Initial			
		plans of correction for each			Date Report Received			
	·	the facility had hired a new			Check If Abnormal			
		d she began working in late			Date MD Notified MD Respo	nse:		
	, , ,	17. He indicated he felt the the right direction in regard			New Order or No New Order Nurse Note:			
	, ,	ed for F278 and F282. The			Family Notified			
	Administrator stated				An In-service was initiated by the Dire	ctor		
		ew pharmacy consultant had			of Nursing on 11/8/17 to 100% of all			
	' '	h the facility within the last			licensed nurses related to the process			
		e numerous changes may			they will follow once they receive an or			
		deficiency at F329, but he			for a lab to be obtained. Nurses will no			
		ce in the new providers.			work until they have received the			
					in-service and this in-service will be			
					included in new nurse orientation.			
					The Unit Manager will review the lab lo Monday through Friday x 2 weeks, the			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	PLE CONSTRUCTION G	1 00		SURVEY LETED
		345051	B. WING _			10/2	26/2017
	ROVIDER OR SUPPLIER EALTH AND REHABILIT.	ATION		STREET ADDRESS, C 405 SOUTH GREENI WADESBORO, NO			
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F 520	Continued From page	e 54	F	twice weekly weeks, then revealed of the were carried of the were carried of the were carried of the Director weekly x 8, the and concerns practice is concorrection. An at the time of be re-educate will be revised maintain Reg Director of Nuther results of weeks, then reconcerns. The Director of results of the Quality Assur months for the recommendate the process. 2) A PASRR so NC Must with for Resident #10/30/17 due Condition as response was NC Must to re PASRR numbers.	gnostic Log will be turned in or of Nursing for review then monthly x 1 for trends is to ensure the facility impliant with current Plandary concerns will be corrected discovery and the staff with ed. The Plan of Corrections of discovery and the staff with ed. The Plan of Corrections of as deemed necessary to gulatory Compliance. The tursing will review and initial the Lab monitoring tool x monthly x 1 for trends and of Nursing will report the Lab monitoring tool to the rance Committee monthly ends, concerns, and tions for any modification ascreening was submitted to the appropriate paperwork as to his Significant Change indicated in the care plants received on 10/30/17 froetain the resident sexisti	ders in of of oted iill o al al a 8 l/or ex 3 of to rk on a in A om	

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	ROVIDER OR SUPPLIER EALTH AND REHABILITA	ATION		STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET WADESBORO, NC 28170			
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F 520	Continued From page	e 55	F 5	related to Level 11 PASRR for Change in Condition by the R Clinical Manager on 11/1/17. information will be included in Worker orientation packet for Work hires. A 100% audit of all residents PASRR Level II was complete 10/31/17 by the Regional Clinfor the past 6 months to assus significant change of condition occurred without notification thas the care plans indicates. Note that with a Level II PASR to have had a significant chart condition. The Regional Clinical Manager and in-service to the Social Worker had a significant chart condition. The Regional Clinical Manager and in-service to the Social Worker had a significant chart condition. The Regional Clinical Manager and in-service to the Social Worker had significant change in condition PASRR Level II resident to Notification that the discovery of the significant change in condition that the process during oriental prior to working the floor. The MDS nurse will update the and submit a Level II PASRR NC Must in the event a reside significant change in condition new Social Worker starts on its educated on the requireme Level II PASRR by the Director upon hire.	Regional This In the Social In	ger t ted d the ne ty,	

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F 520	Continued From page	÷ 56	F	Utilizing a Significant of PASRR Level II QI Au will review the MDS so completed assessmer weeks, and then month that any significant chassessment that was PASRR Level II reside Nurse or Social Worke Must of the significant indicated on the reside The Director of Nursin initial the QI Audit tool monthly x 1 month for The Director of Nursin results of the monitoria Assurance Committee months for trends, cor recommendations for the process. F 329 1) The Physician was duplicate antibiotic the #71 on 10/24/17 by th orders were received Augmentin at that time completed the course 10/29/17 as ordered. orders was due to failin notify the physician of ordered antibiotic. The Regional Clinical an in-service to the Ur Director of Nursing on medication therapy or medication therapy or	dit Tool, the DON chedule of hts weekly x 8 thly x 1 to ensure ange of condition completed for a ent, that the MDS er has notified NC change as ent care plan. In a will review and weekly x 8, then trends or concerns. In a will report the ng to the Quality emonthly x 3 incerns, and any modification of the erapy for Resident e Unit Manager and to discontinue e. The resident of Doxycycline on The duplication of the previously Manager provided in Manager and to duplicate Manager and duplicate	

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NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP COL	DE I	10/20/2011
ANCONU	EALTH AND DEHAD	LITATION		405 SOUTH GREENE STREET		
ANSON H	EALTH AND REHAB	ILITATION		WADESBORO, NC 28170		
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F 520	Continued From p	page 57	F 5.	in-service of the nursing staff 11/01/17 by the Director of N documenting in the order the medications ordered by the p also reviewing to see if multipare being used, and reporting duplication orders to the Phys. The in-service was completed 11/17/17. Licensed nursing swork the floor until they have in-service. Newly hired licens will receive the education durorientation. On 10/30/17, the Unit Manag 100% audit of the Medication Administration Records for unduplication of antibiotic medic ordered in the past 30 days. in-service was completed on instances of duplicate therap All newly hired licensed nurse the education during orientation nursing staff will not work the they have signed the in-service was accompleted by the Manager Monday through Friweeks, then twice weekly x 6 include weekends, then twice include the weekend x1 monton concerns will be corrected by Manger as they are discovered Director of Nursing will review the weekly audits x 8 weeks, x 1 for trends and concerns aplan of correction as needed	ursing on indication for physician and ple antibiotics of antibiotic sician. d on staff will not signed the sed nurses ring der initiated a nunecessary cations The 11/17/17. No y were found. es will receive ion. Licensed of floor until ce. ring QI audit unit iday x 2 is weeks to be monthly to the Unit ed. The w and initial then monthly and adjust the	

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F 520	Continued From page	e 58	F	The res Quilmp mo rec the 2)F rec dos by 10/ sch her red over well Psy The pha Aug aud rec pricipha foul folliby On Ma Dire pha and and and and and and and and and an	pulatory compliance. The Director of Nursing will present to sults of the monitoring at the montivality Assurance Performance provement (QAPI) Committee meanthly for 3 months for review and commendations for any modification of the monitoring process. The Resident #85's pharmacy commendation of 8/23/17 for a grasse reduction of Lexapro was review the Psychiatric Nurse Practitioner has been decided the resident for a full review resident for a full review resident to assure recommendation re reviewed timely by the physicial yehiatric Nurse Practitioner. The Director of Nursing reviewed all armacy consults for the months of gust 2017 and September 2017. The commendations were not completed on 10/31/17. Montioner meaning the process of the next pharmacy review. A parmacy recommendations that we are not completed in the audit were owed up on by the Director of Nursing and Unit Manage armacy recommendation completed an in-service with the process. The attending sysician received an in-service by the process of the process. The attending sysician received an in-service by the process of the process of the process. The attending sysician received an in-service by the process of the process.	eting on of dual wed on ack of s n and The ultiple ed I re e rsing	

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F 520	Continued From page	÷ 59	F 52	Regional Clinical Manager on 10/31/ timely responses to pharmacy recommendations, and the Psychiatr Nurse Practitioner received the in-se by the Director of Nursing on 11/2/17 Utilizing a Pharmacy Recommendatic Audit Tool, the Unit Manager will revi- the pharmacy report monthly to ensu- that all recommendations have been returned completed appropriately by physician and Psychiatric Nurse Practitioner prior to the next pharmac review. The Director of Nursing will review and initial the QI Audit Tool may x 3 for trends and concerns. The Director of Nursing will report the results of the monitoring at monthly Quality Assurance Quality Improvem (QAPI) Committee meeting X 3 mont for review and recommendations for modification of the process.	ic rvice on QI ew re the cy onthly ent	