PRINTED: 03/19/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345534	B. WING		C 02/15/2018
NAME OF PROVIDER OR SUPPI	LIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	02/19/2010
PREFIX (EACH DE	MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE COMPLETION
I	nvestigation was conducted from ugh 02/15/18. Immediate jeopardy	F 00	00	
CFR 483.10 a	at tag F 580 at a scope and severity			
Substandard (Immediate jeo	0 and F 686 constituted Quality of Care. pardy began on 01/09/18 and was 2./15/18. An extended survey was			
SS=J CFR(s): 483.1 §483.10(g)(14 (i) A facility muconsult with the consistent with representative (A) An accider results in injurphysician inter (B) A significant mental, or psyndeterioration in status in either clinical complication (C) A need to a need to discurrent due commence a results in either clinical complication in status in either clinical complication in the clinical complex com	nt change in the resident's physical, vchosocial status (that is, a in health, mental, or psychosocial in life-threatening conditions or locations); alter treatment significantly (that is, continue an existing form of it to adverse consequences, or to new form of treatment); or	F 58	30	2/26/18
resident from (§483.15(c)(1)(to transfer or discharge the the facility as specified in (ii).		TITLE	(X6) DATE

Electronically Signed 03/04/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

Facility ID: 20050005

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		` '	` ′		(X3) DATE SURVEY COMPLETED	
		345534	B. WING		C 02/15/2018	
	ROVIDER OR SUPPLIER HEALTH & REHABILITA			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	02/13/2010	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION	1
F 580	(14)(i) of this section, all pertinent informati is available and proviphysician. (iii) The facility must a resident and the resident as specified in §483. (B) A change in resident (e)(10) of this section (iv) The facility must update the address (phone number of the representative(s). §483.10(g)(15) Admission to a computati is a composite degree §483.5) must discloss its physical configural locations that compripant, and must specifications that compribations that compribations that comprises its physical of the resident of the physician of the resident of the physician of pressure in treatment from 1/9 failed to get the physician of pressure	ification under paragraph (g) I the facility must ensure that on specified in §483.15(c)(2) ided upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ons as specified in paragraph intercord and periodically mailing and email) and resident osite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct ify the policies that apply to en its different locations or is not met as evidenced sician, Physician Assistant consultant interviews and cility failed to notify the lent's pressure ulcers on the	F 58	Preparation and or execution of does not constitute admission of agreement by the Provider of the facts alleged or conclusion set statement of deficiencies. The prepared and executed solely be is required by the provisions of Federal law. Resident #1 no longer resides in the president #2 is the president #3 is the previous solely be in the president #4 in the previous solely be	or ne truth of forth on the plan is pecause it State and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PLUI DING					(X3) DATE SURVEY COMPLETED		
			A. BUILDI	NG		l ,	С
		345534	B. WING _				/15/2018
NAME OF P	ROVIDER OR SUPPLIER		,	S1	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CANFORE	NUCALTU O DELIADU I	FATION CO		27	702 FARRELL ROAD		
SANFURL	HEALTH & REHABILIT	IATION CO		S	ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	pressure ulcers. The physician of the work and seek an order for sacral pressure ulces size" suspected deem aroon area of discont/09/18. It was desunstageable sacral pressure ulces and the sacral pressure ulces are unstageable sacral pressure that it is a continued or the sacral pressure that is a continued and the sacral pressu	at orders for Resident #1's e facility failed to notify the sening of the pressure ulcers or treatment. Resident #1's or was described as "quarter p tissue injury (purple or colored intact skin) on oreibed on 01/22/18 as an oressure ulcer measuring) length, 12.5 cm width and p excessive necrotic tissue ack in color and as dent #1 was hospitalized with oressure ulcer requiring sharp	F.	580	facility. The nurses were unsure to call the Medical Director for treatment orders when the attending physician was unable to be reached. There was a lack of foll through by nursing to assure orders we received for treatment and a lack of oversight to identify and treat any worsening wound condition. The Treatment Nurse was removed fro completing treatments 2/14/18 and retraining initiated. Floor staff will complete treatments beginning 2/14/18 until the Treatment Nurse's retraining is completed.	ow ere m	
	Resident #1 when the Physician #1 of the failed to obtain treat resident's delay in the 1/12/18. On 01/12 began implementing approval of the physician Consultant treatment Resident #1's pressito receive approval starting new pressure The facility failed to worsening of the pressure ulcer worse with an infected stag sharp debridement a Immediate jeopardy when an acceptable	began on 01/09/18 for the facility failed to notify resident's pressure ulcers and ment orders, resulting in the eatment from 1/9/18 till /18, the Treatment Nurse is treatment orders without sician. The facility failed to of the Wound Nurse at orders on 1/15/18 for ure ulcers. The facility failed of the physician before the ulcer treatment on 1/16/18. In the physician of the essure ulcers on 1/22/18 and the eatment. Resident #1's the end and he was hospitalized go 4 pressure ulcer requiring and antibiotic therapy. Was removed on 02/15/18 credible allegation was a remains out of compliance			A 100% audit of all current residents with a wound was completed by the Region Clinical Consultant on 2/15/18 to verify physician and Responsible Representative notification of the wound was completed when discovered. Three instances lacked Responsible Party notification at the time of discovery. In those 3 instances, the wound was a surgical incision and the resident was deemed alert and oriented. One instated of delayed notification was noted. The Responsible Representative was contacted on 2/15/18 by the Unit Mana and given the history and current status the wound. The Staff Development Coordinator initiated an in-service on 2/15/18 to 100 of all nursing assistants on reporting skichanges noted during care by completing skichanges noted during care by care skichanges noted during care by completing skichanges noted during care by care skichanges noted during care skichanges noted during skichanges noted during	al dee nce ger s of	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245524	B. WING			С
NAME OF B	201/1252 02 01/221/52	345534	B. WING			2/15/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SANFORD	HEALTH & REHABILITA	ATION CO		2702 FARRELL ROAD		
				SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From page 3		F 58	00		
1 300	at a lower scope and no actual harm with t minimal harm that is ensure monitoring an in-serviced. The findings included Resident #1 was adn 01/09/18 with cumula Parkinson's disease, Disease, Dysphagia Prostrate, urinary returnary catheter. Review of Resident #	severity of D (isolated with the potential for more than not immediate jeopardy) to ad that all staff have been the second title to the facility on attive diagnoses of Peripheral Vascular and Benign Hypertrophic tention with an indwelling the second seco	F 36	a full body shower sheet and so the sheet to the Charge Nurse. Development Coordinator initial in-service on 2/14/18 to 100% of licensed staff to complete admission/re-admission head to assessments and weekly head assessments with documentatic assessment in the electronic more record. The in-service will incluse the physician for treatment ordewounds identified with the administration and what to do when a new skin issessidentified and notification to the treatment orders, Responsible	The Staff ated an of all o toe skin on of the nedical ide calling ers for all hission skin cluded sue is e MD for	
		s ordered a skin assessment sday and no treatment ulcer.		Representative, Treatment Nur Unit Managers. All newly hire staff will receive the appropriate during orientation. No staff will	d nursing e education	
	dated 01/09/18 at 4:3 quarter sized open at	t1's admission nursing note 66 PM read there was a rea on his right buttock which		the in-service is completed. Co action completed on 2/26/18.	orrective	
				Utilizing a Wound Notification C Tool, the Unit Managers will rev Wound Communication Book to the physician and Responsible Representative has been notification.	view the o assure	
	Report dated 01/09/1 admitted with an unsing his right buttock meal length, 7.5 cm width a described as 40% esskin) and 60% granul capillaries formed are report was completed.	8 read Resident #1 was tageable pressure ulcer to suring 3.5 centimeters (cm) and 0.5 cm depth. It was char (dry, dark scab of dead lation (pink tissue containing bund the wound edges). The d by the Treatment Nurse tan #1 was notified on		new wound.Monitoring will occur through Friday x 2 weeks then weekly x 2 weeks, then weekly then monthly x 1 month. The Supervisor will complete the auweekend x 2. Using an Admiss Wound QI Tool, the Unit Managreview all new admission/re-adrecords to assure a skin assess completed on admission and a identified skin issues were add	ur Monday twice x 4 weeks, Weekend udit on the ions gers will lmission sment was ny	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345534	B. WING _			02	C 2/15/2018
	ROVIDER OR SUPPLIER DHEALTH & REHABILITA	ATION CO		27	TREET ADDRESS, CITY, STATE, ZIP CODE 702 FARRELL ROAD ANFORD, NC 27330	1 02	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Report dated 01/09/1 admitted with an unsideep tissue injury, promeasuring 3.5 cm ler report was completed and indicated Physicio 01/09/18 with treatmed Review of Resident Report dated 01/09/1 admitted with an unsihis left buttock measured length, 7.5 cm width adescribed as 60% Estone The report was compounted and indicated 01/09/18 with treatmed Review of Resident Administration Recort treatment orders to his sacrum from 01/09/18 Review of the electro 01/12/18 at 11:10 AM Nurse entered the folion to the electronic physicauto-populated the Treatment orders to be cleansed dry and Calmosepting antiseptic, antiprurition combination) was to with Silver Alginate (alabsorbent wound drewound bed. It was to	this Wound Assessment 8 read Resident #1 was tageable, due to suspected tessure ulcer to his sacrum tigth and 7.5 cm width. The tid by the Treatment Nurse tian #1 was notified on tent orders pending. this Wound Assessment 8 read Resident #1 was tageable pressure ulcer to turing 3.5 centimeters (cm) and 0.5 cm depth. It was tichar and 40% granulation. The orders pending. this January 2018 Treatment the orders pending. this January 2018 Treatment d (TAR) included no tis bilateral buttocks and 8 through 01/12/18. The orders which treatment Administration treatment Administration treatment Administration treatment (analgesic,	F	580	a treatment order, progress note, notification to the MD and RP was mad and notification was completed in the Wound Communication book. The Director of Nursing will review the Audit Tools weekly x 8, then monthly x for trends and concerns The Director of Nursing will report the results of the monitoring to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification the process. The Administrator will be responsible for implementing the plan of correction.	QI 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		, , ,	(X3) DATE SURVEY COMPLETED			
		345534	B. WING			C 2/15/2018
NAME OF PR	ROVIDER OR SUPPLIER	0.0001		STREET ADDRESS, CITY, STATE, ZIP COD		2/15/2016
				2702 FARRELL ROAD		
SANFORD	HEALTH & REHABILIT	ATION CO		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From page 5 F 580					
	written physician ord	orders for this treatment (A er requires the prescriber to er with his/her signature).				
	#2 on 02/14/18 at 3:2 admitted Resident #7 his initial skin assess on his sacrum. She wound communication Treatment Nurse on Nurse #2 stated the contacted for orders pressure ulcer. She stated the state of the sta	for every new or worsening stated it was the reatment Nurse to contact				
	Treatment Nurse star of any pressure ulcer 01/12/18. When quest Assessment Reports on Resident #1, the must have dated the it should have been as the did not recall ask Resident #1 on 01/08 Wound Assessment Treatment Nurse star wound communication facility provided no ecommunication form 02/15/18. The Treatment found out about Resident #1 on 01/12/18, she notified (PA) who gave her the entered in the electrobut she must have for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345534	B. WING			C 2/15/2018
	ROVIDER OR SUPPLIER D HEALTH & REHABILIT.			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		2/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	#1. An Interview was cor 02/14/18 at 1:30 PM. give any treatment or because he was und and it was an unacce give orders or directic stated she did not recasking her for advice worsening of Resider PA stated Resident # facility Wound Nurse Physician #1 was into 02/13/18 at 3:50 PM. in office 01/09/18 through the facility let him admitted but he was request for treatment the request for treatment to uncer. Based on record reviphysician, physician, physician, physician Treatment Nurse, the admitting nurse (Nurse notified the phypressure uncer and the 1/9/18. The resident and treatment of the till 1/12/18. Also their treatment nurse got a size of the size of the size of the till 1/12/18. Also their treatment nurse got a size of the size of t	nducted with the PA on The PA stated she did not reders for Resident #1 er the care of Physician #1 eptable medical practice to on on Resident #1. She call the Treatment Nurse or orders regarding the nt #1's pressure ulcers. The that was being followed by the Consultant. erviewed via Telephone on Physician #1 stated he was bough 01/12/18 and noted in know that Resident #1 was	F 58			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345534	B. WING _			C 02/15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	'	02:10:20:10
(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 COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	indicated documente was completed with Alginate to his sacru There was no docum appearance of his sa 01/13/18 or 01/14/18 There was no documulcer wound was eve 01/09/18 until the Withe area on 01/15/18 Review of the Wound dated 01/15/18 read unstageable pressur measuring 3.5 cm lecm depth. It was desine measuring 3.5 cm lecm depth. It was desine measuring the measuring debridement complement complement complement complement complement complement of (wound dressing malginate, a highly-ab extracted from brown dressing daily and accept the wound Nurs recently took over that the facility. She st	#1's January 2018 TAR ed initials that his treatment Calmoseptine and Silver m on 01/13/18 and 01/14/18. hented description of the acral pressure ulcer on 3. hentation that the pressure er assessed again after ound Nurse Consultant saw 3. d Nurse Consultant report Resident #1 had an re ulcer to his sacrum ngth, 7.5 cm width and 0.5 cribed as having excessive aring yellow/black in color. d serous drainage with no ated there was no ted and new orders for Il-grade honey products for wounds), Calcium Alginate de with the ingredient sorbent substance that is n seaweed) and a foam	F	580		
	his sacrum. She stat	cium Alginate to all areas on ed it had been her g with the Treatment Nurse				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (XD) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345534	B. WING			C)2/15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		12/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 580	Physician #1. During an interview of Treatment Nurse state new order written in report on 01/15/18. There was no evider notified the physician Consultant new order implemented. Resident #1's admiss (MDS) dated 01/16/1 impairment with no be requiring extensive a and total assistance Resident #1 was concatheter, always incompared with two understands of the electron 01/16/18 at 1:06 AM Nurse entered the form auto-populated the Trunstageable wound is spray (gentle antimic broad-spectrum bacters).	e 8 ew orders and contacted on 2/14/18 at 12:05 PM, the ted that she never saw the the Wound Nurse Consultant of the Wound Nurse of the Wound Nurse rs or that the orders were sion Minimum Data Set 8 indicated severe cognitive ehaviors. He was coded ssistance with bed mobility with toileting and hygiene. led for an indwelling urinary ontinent of bowel, and as estageable pressure ulcers. onic physician orders dated revealed the Treatment llowing new treatment which AR: cleanse Resident #1's o his sacrum with Anasept robial wound cleanser with ericidal properties) for odor dry and apply Calmoseptine	F 5	·		
	to the peri-wound the the wound bed only. daily and as needed physician orders for evidence that the physician treatment.	en apply Calcium Alginate to Cover with a foam dressing There were no written this treatment. There was no ysician approved the change on 2/14/18 at 12:05 PM, the ted that, regarding the				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345534	B. WING _			C 02/15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	<u>'</u>	02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	1/16/18, the Wound those orders on 01/12 Consultant was resp treatment orders. The she only entered the electronic medical resaw an original written. During a telephone in PM, the Wound Nurshad not spoken with Resident #1's presson. Review of Resident Report dated 01/22/ unstageable pressur status deteriorated in cm width with no downs completed by the indicated Physician with no new orders. Review of Resident Report dated 01/22/ unstageable pressur with no new orders. Review of Resident Report dated 01/22/ unstageable pressur unchanged measuring width with no document to make the province of the physician #1 was not new orders.	r for treatment change on Nurse Consultant gave her 5/18 but the Wound Nurse onsible for writing her own e Treatment Nurse stated new treatment order into the ecord on 01/16/18 and never en order. Interview on 02/13/18 at 3:10 se Consultant confirmed she Physician #1 regarding	F5			
	status deteriorated n cm width and 0.3 cm 60% Eschar, 30% sl	e ulcer to his left buttock neasuring 7.5 cm length, 3.5 I depth. It was described as ough and 10% granulation. derate serous drainage with				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 02/15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CO		STREET ADDRESS, CITY, STATE, ZIP COD 2702 FARRELL ROAD SANFORD, NC 27330		52/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 580	Physician #1 was not new orders. Review of the Wound dated 01/22/18 read unstageable pressure measuring 13.5 cm led cm depth. It was des necrotic tissue appear and as deteriorated, serous purulent drain indicated there was read no new orders. To continue with Medinfoam dressing daily at the pressure ulcer newound care. The plant consultant for wound included a Complete Comprehensive Metapre-albumin (marker used to help detect a malnutrition). Review of Resident # indicated documente were completed to his	ion. The report was patternent Nurse and indicated tified on 01/22/18 with no different Nurse and indicated tified on 01/22/18 with no different Nurse Consultant report Resident #1 had an ender the ulcer to his sacrum ength, 12.5 cm width and 1.5 cribed as having excessive earing yellow/black in color. There was noted moderate hage with no odor. The note no debridement completed. The treatment was to oney, Calcium Alginate and a land as needed. In the physician was entation of the pressure sores. #1's progress notes dated ent #1 had a 4.0 length with pressure ulcer. The note read teded debriding and intense in read to consult the wound care. Additional orders. Blood Count (CBC), abolic Panel (CMP) and of nutritional status and was and diagnose protein-calorie. #1's January 2018 TAR di initials that his treatments is sacrum with Anasept spray et on 01/25/18, 01/26/18,	F 5	80		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345534	B. WING		0.	C 2/15/2018
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT	1 111		STREET ADDRESS, CITY, STATE, ZIP CO. 2702 FARRELL ROAD SANFORD, NC 27330		2/13/2016
(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 IE APPROPRIATE	(X5) COMPLETION DATE
F 580	Continued From pag	e 11	F 5	30		
	read Staphylococcus Resident #1's sacrur	ound culture dated 01/28/18 s Aureus was present in n. It was noted the results of ere faxed to Physician #1 on				
	Physician #1 was aw result and there were Physician #1 stated	ote dated 01/28/18 read ware of the wound culture eno new orders except would treat with Levaquin 1/25/18 for pneumonia.				
	that on 01/28/18 at 9 responsible party (RI sent to the hospital for antibiotics. Physician	note dated 01/29/18 read: 30 PM, Resident #1's P) requested Resident #1 be or intravenous (IV) #1 was contacted and asferred to the hospital as				
	o1/29/18 read Reside severe sepsis secon infection and an infection debridement was constage 4 sacral pressilength, 12 cm width a muscle. He was start and IV antibiotics. Re	al admission summary dated ent #1 was admitted with dary to a urinary tract cted pressure ulcer. Bed-side expleted on 01/29/18 of a cure ulcer. It measured 10 cm and depth was down to the ded on wound management esident #1 was discharged 02/09/18 to another facility.				
	Director of Nursing (I facility standing orde worsening pressure expectation that who would communicate would then communicate	on 02/15/18 at 12:05 PM the DON) stated there were no rs for the treatment of new or ulcers. She stated it was her ever found a pressure ulcer it to the floor nurse who cate it to the Treatment Nurse was then to notify				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C 02/15/2018	
		345534	B. WING				
	ROVIDER OR SUPPLIER DHEALTH & REHABI			STREET ADDRESS, CITY, STATE, ZIP C 2702 FARRELL ROAD SANFORD, NC 27330		2/15/2016	
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 580	treatment. The Do where the Treatment orders she implement orders she implement of the present of the need of Resion admission and of the pressure ulchis expectation the re-attempted to conotified him of worders on admission and provided any Physician #1 state #1's pressure ulce Telephone on 2/13 Director stated he the new Wound Capparently replace weeks ago. He state Wound Nurse residents with pressure ulce would not have be orders for Resider expectation Physician that would not have be ordered for treatment of the state of the st	sician to obtain orders for ON stated she did not know ent Nurse was getting the nented for Resident #1. Interviewed via Telephone on PM. Physician #1 stated he was residents in the facility. He ler the impression that Wound was also involved in the lent #1's pressure ulcer. In the facility did not notify him sident #1 for treatment orders did not notify him of worsening pers. Physician #1 stated it was not the facility would have entact him for treatment orders, resening of the pressure ulcers treatments as ordered. In the worsening of Resident was likely avoidable. It was interviewed via Physician #1 he Medical was unaware until recently of are Management providers that and the previous providers two ated he was under impression Consultant was following all assure ulcers. He stated there essistant (PA) at the facility friday but Resident #1 was a services of Physician #1 and the involved in giving treatment at #1. He stated it was his cian #1 would have been	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345534	B. WING_	B. WING		C 02/15/2018	
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT			STREET ADDRESS, CITY, STATE, ZIP CO 2702 FARRELL ROAD SANFORD, NC 27330		J2/13/2016	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 580	orders for new or wo rather the nurse was physician each time stated when an order attending physician, or the Physician Assi that the original order prescriber's signature electronic medical restated nothing should electronic medical rewritten order. The Adexpectation that resignew or worsening preattending physician but the Administrator was jeopardy on 02/15/18 Administrator provide Allegation: Resident#1 no longer The nurses were unsupplied in the physician was unabled a lack of follow throu orders were received oversight to identify a wound condition. The Treatment Nurse	the facility had no standing reening pressure ulcers but to notify the responsible for specific orders. She is received from the the Wound Nurse Consultant estant, it was her expectation in the written with the entered into the cord. The Administrator did be entered into the cord unless there was a diministrator stated it was her dents be assessed timely for essure ulcer and the period timely. The Administrator did be entered into the cord unless there was a diministrator stated it was her dents be assessed timely for essure ulcer and the period timely. The Administrator did the second timely for essure ulcer and the period timely. The Administrator did to the cord unless there was a diministrator stated it was her dents be assessed timely for essure ulcer and the period timely. The Administrator did to the cord unless there was a diministrator stated it was her dents be assessed timely for essure ulcer and the period timely. The Administrator did to the cord unless there was a diministrator stated it was her dents be assessed timely for essure ulcer and the period timely. The Administrator did to the cord unless there was a diministrator stated it was her dents be assessed timely for essure ulcer and the period timely.	F 5	80			
	initiated. Floor staff beginning 2/14/18 ur retraining is complete	ts 2/14/18 and retraining f will complete treatments htil the Treatment Nurse' ed. ent residents with a wound					
	A 100 /6 audit all Culf	CIIL ICSIUCIILS WILLI A WUUIIU					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345534	B. WING _		C 02/15/2018			
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	I	02/10/2010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 580	Responsible Repres wound was complete instances lacked Rethe time of discovery wound was a surgical was deemed alert and delayed notification of Representative was Unit Manager and gitthe wound. The Staff Development of the wound of the wound. The Staff Development of the wound of the wou	le Regional Clinical 18 to verify physician and entative notification of the ed when discovered. 3 sponsible Party notification at v. In those 3 instances, the al incision and the resident and oriented. One instance of was noted. The Responsible contacted on 2/15/18 by the ven the history and status of ent Coordinator initiated an 3 to 100% of all nursing and skin changes noted during a full body shower sheet and to the Charge Nurse. The coordinator initiated an 3 to 100% of all licensed staff on/re-admission head to toe and weekly head to toe skin ocumentation of the lectronic medical record. The e calling the physician for all wounds identified with the ssment. The in-service when a new skin issue is ation to the MD for treatment Representative, Treatment lagers. All newly hired	F 5	80				
	Unit Managers will re Communication Boo	otification QI Audit Tool, the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	COMPLE	(X3) DATE SURVEY COMPLETED		
	345534 B. WING		B. WING		C 02/1!	5/2018	
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT.	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	1 02/10	3/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 580	through Friday x 2 wweeks, then weekly month. The Weeker the audit on the weel Admissions Wound C will review all new ac records to assure a scompleted on admississues were address progress note, notific made, and notification Wound Communication Nursing will review the then monthly x 1 for the Director of Nursithe monitoring to the Committee monthly x concerns, and recommodification of the promodification worsening of pressure ulceridentification worsening of pressure ulceridentification of the promodification worsening of pressure ulceridentification worsening and staff pressure training and staff who	conitoring will occur Monday eeks then twice weekly x 2 x 4 weeks, then monthly x 1 and Supervisor will complete kend x 2. Using an QI Tool, the Unit Managers limission/re-admission ekin assessment was sion and any identified skin eed with a treatment order, eation to the MD and RP was in was completed in the fon book. The Director of the QI Audit Tools weekly x 8, trends and concerns. In will report the results of Quality Assurance is 3 months for trends, imendations for any forcess. If be responsible for idible allegation of removal In was verified on 02/15/18 ince by staff interviews on in of new pressure ulcers or the east of the control of the contro	F 58				

		IDENTIFICATION NUMBER.		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345534	B. WING		C 02/45/2048
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT	1 111		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	02/15/2018
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 686 F 686 SS=J	CFR(s): 483.25(b)(1	revent/Heal Pressure Ulcer)(i)(ii)	F 68		2/26/18
	resident, the facility in (i) A resident received professional standar pressure ulcers and ulcers unless the indidemonstrates that the (ii) A resident with professional standar promote healing, present with professional standar promote healing, present ulcers from device This REQUIREMENT by: Based on staff, physical Wound Nurse Consumeration orders to immediatel pressure ulcer on addressure ulcer on addressure ulcer, failed a pressure ulcer, failed a pressure ulcer (Resident #1 winfected stage 4 present pressure ulcer (Resident #1 winfected stage 4 present present pressure ulcer (Resident #1 winfected stage 4 present present present present present present present provide ulcer. Resident #1 winfected stage 4 present present present present present present provide ulcer and consultant's orders of present present provide ulcer. Resident #1 winfected stage 4 present p	ehensive assessment of a must ensure that- es care, consistent with do of practice, to prevent does not develop pressure lividual's clinical condition ey were unavoidable; and ressure ulcers receives and services, consistent indards of practice, to event infection and prevent eloping. T is not met as evidenced sician, physician assistant, altant interviews and record illed to obtain physician y initiate the treatment of a limitiate the treatment of a limitiate the worsening of a did to prevent the worsening of a did to prevent the worsening of a follow Wound Nurse of a resident admitted with a dent #1), and failed to treatment to the pressure was hospitalized with an		Resident #1 and Resident #2 no long reside in the facility. There was a lack of communication between care providers; nursing staff were not consulting the doctor before initiated treatment. There was confus if there was a standing order or protoc or not. Also, there was a treatment no being provided as ordered due to the failure of the treatment nurse to comp treatments as ordered by the physicia. The Treatment Nurse was removed for completing treatments 2/14/18 and retraining initiated. Floor staff will complete treatments beginning 2/14/1 until the Treatment Nurse s retraining completed. The Charge Nurse will be responsible for providing wound	they ion col ot lete n. om

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING			C 02/15/2018	
NAME OF P	ROVIDER OR SUPPLIER	0.000.	<u> </u>	9	STREET ADDRESS, CITY, STATE, ZIP CODE	02/	15/2016
TVAIVIL OF T	NOVIDER OR GOLT EIER				702 FARRELL ROAD		
SANFORE	HEALTH & REHABILI	TATION CO					
					SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP			(X5) COMPLETION DATE
F 686	F 686 Continued From page 17		F 6	686			
	treatment, failed to	obtain physician orders before			treatments in the event the Treatment		
		pressure ulcer (Resident			Nurse is absent from work or assigned		
		d a stage 4 pressure ulcer			other duties.		
	requiring debrideme	- ·					
		s for 2 (Resident #1 and			A 100% of all current residents residing	ງ in	
	Resident #2) of 4 re	sidents reviewed for pressure			the facility received a head to toe skin		
	ulcers.				audit that was initiated on 2/13/18 and		
		0.4/0.0/4.0.6			was completed on 2/14/18 by the Unit		
		began on 01/09/18 for			Managers x 2, Staff Development		
		e came in with a pressure d received no pressure ulcer			Coordinator, and Director of Nursing to identify any unreported skin concerns.	1	
		18. The facility provided no			Three new concerns were identified, the	ıe.	
		g orders for pressure ulcer			attending provider was notified and	C	
		2/18, the Treatment Nurse			treatment initiated as ordered by the		
		treatment orders without			attending provider and documented on	Į	
		sician. Resident #1 was seen			the Treatment Administration Record,		
	by the Wound Nurse	e Consultant on 01/15/18 and			entered into the Wound Communicatio	n	
	her orders were not	followed. There was no			Book, and the Responsible		
		ce of Resident #1's receiving			Representative was notified. The Wou		
		ments from 01/09/18 through			Communication Book will be maintaine	d	
		01/18/18, 01/19/18, 01/23/18			at each nursing station and used as a		
		outcome for Resident #1 was			communication tool between the floor		
		pressure ulcer resulting in			nurses and the Treatment Nurse. The		
		an infected stage 4 pressure of debridement and antibiotic			Charge Nurse documents all new skin concerns in the communication book a	nd	
		2 was admitted without any			the Treatment Nurse will review the	iiu	
		01/01/18. Resident #2			Wound Communication Book daily to		
	I -	ea on his sacrum on 01/09/18			ensure any new skin issues are		
		interventions until 01/13/18.			addressed completely.		
	The Treatment Nurs	e began implementing					
	treatment orders wit	hout approval of the			A 100% audit of Treatment Administrat	ion	
	1	ome for Resident #2 was			Records were reviewed with physician		
		1/27/18 with a stage 4			orders for the past 30 days by the Unit		
		harp debridement and			Managers x 2 and the Staff Developme	ent	
		nmediate jeopardy was			Coordinator on 2/15/18 to verify all		
		8 when an acceptable			treatments on the TAR have		
	_	vas provided. The facility			corresponding physician ☐s order and t	ne	
		pliance at a lower scope and			order was transcribed as ordered.		
	seventy of D (Isolate	ed with no actual harm with					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345534	B. WING				C 45/2048
NAME OF P	ROVIDER OR SUPPLIER	0.000.	 	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	15/2018
TVAIVIL OF T	TO VIDER OR OUT LIER						
SANFORD	HEALTH & REHABILITA	ATION CO			702 FARRELL ROAD		
				S	ANFORD, NC 27330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	F 686 Continued From page 18		F 6	86			
		than minimal harm that is dy) to ensure monitoring and in-serviced.			The Wound Consultant will begin writing her own treatment orders as of 2/14/18 while in the facility after her assessment of the wound. The Wound Consult Rewill be reviewed with the provider. All	nt	
	The findings included	:			orders will be transcribed by the Treatment Nurse or Charge Nurse.		
		dmitted to the facility on			The Ote# Development Occasion stars		
	01/09/18 with cumula	•			The Staff Development Coordinator initiated an in-service on 2/15/18 to 10	20/	
	Parkinson's Disease,						
	Disease, Dysphagia and Benign Hypertrophic Prostrate with an indwelling urinary catheter.				of all nursing assistants on reporting sk changes noted during care by complet		
					a full body shower sheet and submittin	-	
		1's admission orders dated			the sheet to the Charge Nurse. The		
		s ordered a skin assessment			Charge Nurse will observe the residen	:∐S	
		sday, a multi-vitamin daily.			skin, notify the physician for treatment		
	There were no admitt	_			orders, transcribe the order to the		
	treatment orders for p				Treatment Administration Record, initiathe treatment, and notify the Responsil	ole	
		1's admission nursing note			Representative. The Charge Nurse wi		
		6 PM read there was a			enter the resident and the skin issue in		
		ea on his right buttock which			the Wound Communication Book for the	е	
		wnish/dark in color with a			Treatment Nurse to review and follow.		
	_	al serosanguinous drainage.			The completed shower sheet will be gi		
		size area to his coccyx.			to the Unit Manager to verify all phases	s of	
		ented evidence that the			the process have been completed.		
	physician or treatmen	it nurse was notified.					
	D . (D , "				The Staff Development Coordinator	201	
		1's Wound Assessment			initiated an in-service on 2/14/18 to 10	J%	
	T	8 read Resident #1 was			of all licensed staff to complete		
		ageable pressure ulcer to			admission/re-admission head to toe sk		
	_	suring 3.5 centimeters (cm)			assessments and weekly head to toe s		
		and 0.5 cm depth. It was			assessments with documentation of the	3	
		char (dry, dark scab of dead			assessment in the electronic medical		
		ation (pink tissue containing			record. The in-service included what to		
		ound the wound edges). The			do when a new skin issue is identified	ailu	
	and indicated Physici	by the Treatment Nurse			notification to the MD, Resident Representative, Treatment Nurse, and		
	01/09/18 with treatme				Unit Managers. The Charge Nurse wil		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
							С	
		345534	B. WING _			02	2/15/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
				2	702 FARRELL ROAD			
SANFORD	HEALTH & REHABI	LITATION CO		s	SANFORD, NC 27330			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 686	Continued From p	age 19	F 6	686				
		_			observe the resident ☐s skin, notify the			
	Review of Resider	nt #1's Wound Assessment			physician for treatment orders, transcri	be		
	Report dated 01/0	9/18 read Resident #1 was			the order to the Treatment Administrati			
	admitted with an υ	instageable due to suspected			Record, initiate the treatment, and notif	fy		
	deep tissue injury	pressure ulcer to his sacrum			the Responsible Representative. The			
	measuring 3.5 cm	length and 7.5 cm width. The			Charge Nurse will enter the resident ar	nd		
		eted by the Treatment Nurse			the skin issue in the Wound			
		sician #1 was notified on			Communication Book for the Treatmen	t		
	01/09/18 with trea	tment orders pending.			Nurse to review and follow. The			
					completed shower sheet will be given t			
		nt #1's Wound Assessment			the Unit Manager to verify all phases o	f		
	Report dated 01/09/18 read Resident #1 was				the process have been completed. All			
		unstageable pressure ulcer to			newly hired nursing staff will receive th			
		easuring 3.5 centimeters (cm) Ith and 0.5 cm depth. It was			appropriate education during orientatio No staff will work until the in-service is	n.		
		Eschar and 40% granulation.			completed. Corrective action complete	۸d		
		impleted by the Treatment			on 2/26/18.	-u		
		ed Physician #1 was notified on			011 2/20/10.			
		tment orders pending.			The Medical Director, Physicians and			
		anon cracio ponanigi			Physician Assistants were all re-educa	ted		
	A telephone interv	iew was conducted with Nurse			on 2/14/18 by the Staff Development			
	•	3:25 PM. Nurse #2 stated she			Coordinator regarding the physician or	der		
	admitted Resident	t #1 on 01/09/18 and completed			process. All physicians understand that	at if		
		essment and noted a small area			we are unable to locate the attending			
		ne stated she completed a			physician or the physician assistant, th	е		
		ation form and gave it to the			Medical Director is responsible for giving			
		on 01/09/18 as she was leaving.			the facility staff orders for the resident.			
		d not recall if the Treatment			This includes wound care orders.			
		Resident #1 on 01/09/18			Otherwise, all physicians and their			
		idmitted at the end of first shift			extenders are responsible for giving			
		t Nurse usually left around 3:00			orders for their residents.			
		ted she was not aware of any			I Milimina a Trackment Decemb			
	_	r the treatment of pressure			Utilizing a Treatment Record			
		he physician had to be			Administration QI Audit Tool, the Unit			
		ers. She stated it was the e Treatment Nurse to contact			Managers or Staff Development Coordinator will review 100% of all			
		garding the missing treatment			treatment records to assure the			
		e #2 stated she provided			treatments have been completed and			
	· · · · · · · · · · · · · · · · · · ·	eatment on 01/24/18 but forgot			signed off by the staff. Monitoring will			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING _	B. WING		C 02/15/2018		
NAME OF P	ROVIDER OR SUPPLIER	1 111		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	2/13/2010	
					702 FARRELL ROAD			
SANFORD	HEALTH & REHABILI	TATION CO			SANFORD, NC 27330			
				_	T			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	Χ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From pa	ge 20	F 6	886				
	to initial the TAR.				occur Monday through Friday x 2 week	S		
					then twice weekly x 2 weeks, then wee			
	During an interview	on 2/14/18 at 11:10 AM,			x 4 weeks, then monthly x 1 month.			
	Nursing Assistant (I	NA) #1 stated on 01/09/18 she			Utilizing a Wound Assessment Manage	؛ r		
		vith Resident #1's skin			(WAM) QI Audit Tool, the Staff			
		urse #2 noted a small area on			Development Coordinator will complete	e a		
		ted Nurse #2 completed a			record review to verify all wounds are			
		ion form and gave it to the efore she left for the day. NA			documented in the WAM to assure all parts of an assessment for 100% of			
		#1 was always cooperative			wounds have been completed weekly.			
		n up daily and laid back down			Monitoring will occur weekly x 8 weeks			
	after lunch.	r up daily and laid baok down			then monthly x 1. Using an Admissions			
					Wound QI Tool, the Unit Managers will			
	During an interview	on 2/14/18 at 12:05 PM, the			review all new admission/re-admission			
	Treatment Nurse st	ated she was not made aware			records to assure a skin assessment w	as		
		ers found on Resident #1 until			completed on admission and any			
		estioned regarding the Wound			identified skin issues were addressed v	vith		
		she completed on 01/09/18			a treatment order, progress note,			
		Treatment Nurse stated she			notification to the MD and Resident			
		e assessment incorrectly and dated 01/12/18. She stated			Representative was made, and notification was completed in the Wour	nd		
		sking for treatment orders for			Communication book. The Director of	iu		
		09/18 as documented on the			Nursing will review the QI Audit Tools			
		t Report dated 01/09/18. The			weekly x 8, then monthly x 1 for trends			
		ated she did not receive a			and concerns.			
	wound communicat	ion form until 01/12/18. The						
	facility provided no	evidence of a wound			The Director of Nursing will report the			
		n at the time of exit on			results of the monitoring to the Quality			
		tment Nurse stated when she			Assurance Committee monthly x 3			
		sident #1's pressure ulcers on			months for trends, concerns, and	_		
		ed the PA who gave her the			recommendations for any modification	OŤ		
	_	rders entered in the electronic 118 but she must have			the process.			
		n original physician order. The			This Administrator will be responsible for	or		
	_	ated she thought the PA could			implementing the plan of correction.	<i>J</i> 1		
	give her orders on F				mipromotion of controlloring			
	-							
		conducted with the PA on I. The PA stated she did not						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED
	345534 B. WING				C 02/15/2018	
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CO		STREET ADDRESS, CITY, STATE, ZIP COD 2702 FARRELL ROAD SANFORD, NC 27330	DE	02/13/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 686	give any treatment or because he was under and it was an unacce give orders or directic stated she did not recasking her for advice worsening of Resider PA stated Resident # facility Wound Nurse Review of the 48-Hou 01/10/18 read Resider pressure ulcers. Interfulcer care, pressure if and wheel-chair. Review of Resident # Administration Recort treatment orders to heacrum from 01/09/18 Review of the electro 01/12/18 at 11:10 AM Treatment Nurse entereatment orders which bilateral buttocks and cleansed with wound Calmoseptine ointment antipruritic, and sking to be applied to the penalty Alginate (an antimicrowound dressing with bed. It was to be covered dressing daily and as written physician order Review of Resident # Review of Review of Resident # Review of Resident # Review of Review of Resident # Review of Resident # Review of Review of Review of Review of Resident # Review of	rders for Resident #1 er the care of Physician #1 eptable medical practice to on on Resident #1. She call the Treatment Nurse or orders regarding the nt #1's pressure ulcers. The 1 was being followed by the Consultant. ur Baseline Care Plan dated ent #1 was admitted with ventions included pressure reducing mattress to the bed et 's January 2018 Treatment d (TAR) included no is bilateral buttocks and 8 through 01/12/18. unic physician orders dated 1 was conducted. The ered the following new ch auto-populated the TAR: I sacrum were to be cleanser, patted dry and ent (analgesic, antiseptic, protectant combination) was eri-wound with Silver obial, highly absorbent ionic silver) to the wound ered with a protective foam is needed. There were no	F	686		
		Calmoseptine and Silver				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMP	(X3) DATE SURVEY COMPLETED	
la unua	C / 15/2018	
NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO SANFORD, NC 27330	13/2010	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686 Continued From page 22 Alginate to his sacrum on 01/13/18 and 01/14/18. Review of the Wound Nurse Consultant report dated 01/15/18 read Resident #1 had an unstageable pressure ulcer to his sacrum measuring 3.5 cm length, 7.5 cm width and 0.5 cm depth. It was described as having excessive necrotic tissue appearing yellow/black in color. There was noted mild serous drainage with no odor. The note indicated there was no debridement completed and new orders for Medi-honey (medical-grade honey products for the management of wounds), Calcium Alginate (wound dressing made with the ingredient alginate, a highly-absorbent substance that is extracted from brown seaweed) and a foam dressing daily and as needed. There was no Wound Assessment Report completed for Resident #1 the week of 01/15/18 through 01/19/18. This was the responsibility of the Treatment Nurse. Review of the written physician orders dated 01/15/18 read Prostat (nutritional supplement used in improving wound healing through nutritional shake that provides supplement calories and protein) were initiated by the Registered Dietician. Review of the electronic physician orders dated 01/16/18 at 1:06 AM, revealed the Treatment Nurse entered the following new treatment which auto-populated the TAR: cleanse Resident #1's unstageable wound to his sacrum with Anasept spray (gentle antimicrobial wound cleanser with		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345534	B. WING	B. WING		C 02/15/2018	
NAME OF P	ROVIDER OR SUPPLIER	0.000.		_	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	15/2016
	to the Little of the Little				2702 FARRELL ROAD		
SANFORD	HEALTH & REHABILITA	ATION CO			SANFORD, NC 27330		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 686	to the peri-wound the the wound bed only. It daily and as needed. physician orders for the Review of Resident # indicated no document treatment was completed Calmoseptine and Sill Review of the archive indicated the Treatment Review of the daily so indicated the Treatment treatments 01/16/18. During an interview of Treatment Nurse statements Nurse statemissing written order 1/16/18, the Wound Nothose orders on 01/18 Consultant was respective treatment orders. The she only entered the electronic medical receives an original written. During a telephone in PM, the Wound Considerently took over the at the facility. She statement orders and Calcinis sacrum. She statement experience in working that she wrote the new her expectation that the	n apply Calcium Alginate to Cover with a foam dressing There were no written his treatment. 1's January 2018 TAR hed initials that his eted to his sacrum with over Alginate on 01/16/18. If the Card Report ent Nurse worked 01/16/18 hed Unit Nurse was assigned all ent Nurse consultant gave her for treatment change on Nurse Consultant gave her for the wound Nurse entertheapten of the word on 01/16/18 and never entertheapten of the word on 01/16/18 and never entertheapten of the wound care and treatments the she first assessed entertheapten of the wound care and treatments the she first assessed entertheapten of the worders of the worders. She stated it was the order she gave to the	F	686	,		
	Resident #1 on 01/15 Medi-honey and Calc his sacrum. She state experience in working that she wrote the new her expectation that the	1/18 and gave new orders for ium Alginate to all areas on ed it had been her g with the Treatment Nurse w orders. She stated it was the order she gave to the 01/15/18 would have been					

,		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 2/15/2018	
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT.			STREET ADDRESS, CITY, STATE, ZIP C 2702 FARRELL ROAD SANFORD, NC 27330		271372016	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 686	Resident #1's admiss (MDS) dated 01/16/1 impairment with no b requiring extensive a and total assistance. Resident #1 was code catheter, always incompared and total assistance of Resident #1 was code catheter, always incompared and Resident #1 was code catheter, always incompared and Resident #1 was considered and Resident #1 was compared and a care of Review of Resident #1 was compared and documented was completed to his and Silver Alginate of Review of Resident #1 indicated documented was completed to his and Silver Alginate of Review of Resident #1 indicated no documented treatment was completed to his and Silver Alginate of Review of the daily sindicated the floor nutheir own treatments assigned to complete 01/18/18.	sion Minimum Data Set 8 indicated severe cognitive ehaviors. He was coded ssistance with bed mobility with toileting and hygiene. ed for an indwelling urinary intinent of bowel, and as stageable pressure ulcers. ssment (CAA) dated ent #1 was admitted with remained at risk for the ional skin impairments. The e plan would be developed. #1's care plan dated 01/16/18 ageable pressure ulcer to his is included the following: inence care, measure the y, report any decline in sician, administer treatments ment. #1's January 2018 TAR d initials that his treatment a sacrum with Calmoseptine in 01/17/18. #1's January 2018 TAR inted initials that his eted to his sacrum with liver Alginate on 01/18/18. chedule assignment sheet rses were responsible for on 01/18/18. Nurse #1 was a Resident #1's treatment on interview on 02/12/18 at 11:30	F	586			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		OMPLETED
		345534	B. WING _			C 02/15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	,	02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 686	initial the TAR. Review of Resident a indicated no docume treatment was compled to a complete the archive indicated the Treatments of the daily sindicated the Treatments on 01/19/ Review of Resident a indicated documente was completed to his and Calcium Alginate Report dated 01/22/2 unstageable pressur status deteriorated mono additional documents was completed by the completed by the completed by the completed by the completed indicated documents and Calcium Alginate Report dated 01/22/2 unstageable pressures deteriorated mono additional documents are completed by the complete the	8 but must have forgotten to #1's January 2018 TAR ented initials that his leted to his sacrum with filver Alginate on 01/19/18. ed Time Card Report ent Nurse worked 01/19/18. chedule assignment sheet ent Nurse was assigned all	F6			
	Review of Resident # Report dated 01/22/ unstageable pressur unchanged measurir width with no docum additional documente pressure ulcer to his completed by the Tre	#1's Wound Assessment 18 read Resident #1's e ulcer to his sacrum was ng 3.5 cm length, 7.5 cm ented depth. There was no ed description of the sacrum. The report was eatment Nurse and indicated tified on 01/22/18 with no				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION IG		X3) DATE SURVEY COMPLETED
		345534	B. WING _			C 02/15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	<u> </u>	02/13/2016
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	Report dated 01/22/ unstageable pressur status deteriorated in cm width and 0.3 cm 60% Eschar, 30% sle There was noted mo no evidence of infect completed by the Tre Physician #1 was no new orders. Review of the Wound dated 01/22/18 read unstageable pressur measuring 13.5 cm le cm depth. It was des necrotic tissue appea and as deteriorated. serous purulent drain indicated there was a and no new orders. Continue with Medi-h foam dressing daily a Review of Resident a indicated no docume treatment was comp	#1's Wound Assessment 18 read Resident #1's e ulcer to his left buttock neasuring 7.5 cm length, 3.5 depth. It was described as ough and 10% granulation. derate serous drainage with ion. The report was eatment Nurse and indicated tified on 01/22/18 with no d Nurse Consultant report Resident #1 had an e ulcer to his sacrum ength, 12.5 cm width and 1.5 cribed as having excessive aring yellow/black in color There was noted moderate hage with no odor. The note no debridement completed The treatment was to oney, Calcium Alginate and a and as needed. #1's January 2018 TAR	F 6			
	indicated the Treatm Review of the daily s indicated the Treatm treatments 01/23/18. Review of a physicia	ed Time Card Report ent Nurse worked 01/23/18. chedule assignment sheet ent Nurse was assigned all n order dated 01/23/18 read ered a wound culture of his				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345534	B. WING		02/15/2018		
	ROVIDER OR SUPPLIER HEALTH & REHABILI	TATION CO	2'	TREET ADDRESS, CITY, STATE, ZIP CODE 702 FARRELL ROAD SANFORD, NC 27330			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 686	Continued From page 27		F 686				
	Treatment Nurse sta missing documenta TAR, she must have	on 2/14/18 at 12:05 PM, the ated that, regarding all the tion for treatments on the e forgotten to initial the TAR eived his treatments on and 01/23/18.					
	indicated no docum treatment was comp Anaspet spray and Review of the daily indicated the floor n their own treatments	eview of Resident #1's January 2018 TAR dicated no documented initials that his eatment was completed on his sacrum with easpet spray and Calcium Alginate on 01/24/18. Eview of the daily schedule assignment sheet dicated the floor nurses were responsible for eir own treatments on 01/24/18. Nurse #2 was signed to complete Resident #1's treatment on					
	01/24/18. During a telephone interview on 02/15/18 at 2:40 PM,Nurse #2 stated she provided Resident #1's pressure ulcer treatment on 01/24/18 but forgot to inital off on the TAR.	I she provided Resident #1's ment on 01/24/18 but forgot to					
	Resident #1 was pro	an order dated 01/25/18 read escribed an antibiotic ten days for pneumonia.					
	01/26/18 read Resid 4.0 cm width sacral the pressure ulcer n wound care. The pla consultant for woun included a Complete Comprehensive Me pre-albumin (marke	n #1's progress notes dated dent #1 had a 4.0 length with pressure ulcer. The note read reeded debriding and intense an read to consult the wound d care. Additional orders e Blood Count (CBC), tabolic Panel (CMP) and r of nutritional status and was and diagnose protein-calorie					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 02/15/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 2702 FARRELL ROAD	DE	1 02/	10/2010
SANFORE	HEALTH & REHABILITA	ATION CO		SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
F 686	Continued From page	e 28	F 6	586			
	indicated documenter were completed to his and Calcium Alginate 01/27/18 and 01/28/1 Review of the final weread Staphylococcus Resident #1's sacrum the wound culture were 01/28/18. Review of nursing no Physician #1 was awaresult and there were Physician #1 stated walready ordered on 0000 Review of a nursing responsible party (Responsible party (Respons	bund culture dated 01/28/18 Aureus was present in It was noted the results of the faxed to Physician #1 on the dated 01/28/18 read the are of the wound culture the note note of the wound culture the note of the					
	An interview was con	ducted on 02/13/18 at 11:10					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDI	.vo_		,	3
		345534	B. WING				15/2018
NAME OF F	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SANFOR	D HEALTH & REHABILIT	ATION CO		2	702 FARRELL ROAD		
SANI OK	TILALITI & KLIIABILIT	ATION CO		S	SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	AM, with the Treatmobegan working at the 2017 but started as a She stated she begamonth ago. The Treathat time, she received days with the previous stated there was a lathe floor staff to here communication noted nursing station. Whe she would know abo documented it in her notebook. She stated communication noted Nurse stated the factor orders for pressure uphysician should be when a new area or The Treatment Nurse to work at 7:00 AM a stated she did not also stand-up meeting with floor staff supervisors she was busy with the working on a cart. During a telephone in PM, the Wound Nurse recently started comher practice not to be stated she chose to a treating pressure ulcers to he lack of debridement. spoken with Physician should be with the pressure ulcers to he lack of debridement.	ent Nurse. She stated she e facility sometime in October a floor nurse on night shift. In doing treatments a few atment Nurse stated during ed no training except for two us treatment nurse. She ack of communications from so she instituted a wound book and placed one at each in a new area was identified, ut it if the nurses wound communication d she checked the wound books daily. The Treatment fility did not have any standing ulcer treatments and the contacted for new orders worsening area was noted. e stated she normally arrived and worked eight hours. She	F	686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
		345534	B. WING			C 2/15/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		12/15/2016	
				2702 FARRELL ROAD			
SANFORD	HEALTH & REHABILIT	ATION CO		SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	Continued From pag	e 30	F 6	86			
	_	on 01/15/18. She confirmed made wound rounds with					
	#1 stated Resident # stated concerns regare performing her duties in January 2018. UM Administrator was not concerns and worsel pressure ulcers. She started on 02/12/18 to concerns related to to stated the Treatment from treatments but it position until the new her on 02/14/18. UM Nurse did not attend meeting where reside She stated the floor it Treatment Nurse to communication form	1 02/15/18 at 11:35 AM. UM 1 was on her unit. She arding the Treatment Nurse is became evident sometime if stated the interim officed and aware of the ning of Resident #1's stated the new Administrator out she was also aware of the Treatment Nurse. UM #1 Nurse was never pulled reather she was left in her of Administrator suspended I #1 stated the Treatment the morning stand up ents were discussed daily. hurses were instructed by the					
	Director of Nursing (I facility standing orde worsening pressure expectation that who would communicate would then communi Nurse. The Treatment the resident's physic treatment. The DON where the Treatment orders she implement	on 02/15/18 at 12:05 PM the DON) stated there were no rs for the treatment of new or culcers. She stated it was her ever found a pressure ulcer it to the floor nurse who cate it to the Treatment at Nurse was then to notify an to obtain orders for stated she did not know Nurse was getting the uted for Resident #1. She mplete wound rounds with					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		345534	B. WING _			l	C 15/2018
	ROVIDER OR SUPPLIER DHEALTH & REHABILI	TATION CO	•	STREET ADDRESS, CITY, STATE, ZIP CO 2702 FARRELL ROAD SANFORD, NC 27330	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD B HE APPROPRIA		(X5) COMPLETION DATE
F 686	rounds were completed Consultant. She state were discussed dail meetings but the Trough The DON stated the notified of the concentration of the concentratio	e but rather thought wound eted by the Wound Nurse ted "Patient at Risk" (PAR) y in morning stand up eatment Nurse did not attend. Interim Administrator was erns about the Treatment ag her treatments but the r did not offer any directive. Interimed wia Telephone on 1. Physician #1 stated he was rough 01/12/18 and noted m know that Resident #1 was and orders. Physician #1 stated ment orders could have expected the facility if they had not received a portage of Resident #1's pressure stated he was responsible for facility. He stated he was	F	686			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED
		345534	B. WING _			C 02/15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILIT.	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		02/13/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE
F 686	Continued From pag		F 6	86		
	apparently replaced to weeks ago. He state the Wound Nurse Corresidents with pressure was a Physician Assi Monday through Frid admitted under the swould not have been orders for Resident # expectation that all nursessure ulcers be as obtained timely, and ordered. The Medical seemed to be a lack communication on the	e part of the facility.				
	Administrator stated orders for new or wo rather the nurse was physician each time is stated when an order attending physician, or the Physician Assist that the original order prescriber's signature electronic medical restated nothing should electronic medical rewritten order. She stated ity Administrator 02/12/18, there was stated she was still ir of concerns related to performing her duties became evident around	the Wound Nurse Consultant stant, it was her expectation in the written with the eight entered into the cord. The Administrator if the entered into the cord unless there was a sated she took over as the con 02/12/18 and prior to an interim Administrator. She envolved and had knowledge to the treatment nurse not is. The Administrator stated it and mid-January 2018 during the stated the Unit Managers				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	TIPLE CONSTRUCTIONS			E SURVEY IPLETED
		345534	B. WING			۰,	C 2/15/2018
	ROVIDER OR SUPPLIER DHEALTH & REHABIL	ITATION CO		STREET ADDRES 2702 FARRELL SANFORD, NO			2/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	F K (EA	PROVIDER'S PLAN OF CORRECT ICH CORRECTIVE ACTION SHOU SS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 686	recently became a were completing sl documenting wheth not-intact. She stated body inspection be narrative description status. She stated aware that the Treattending morning patients at risk (PA stated it was her explained by the stated it was her explained by	Administrator stated she only ware of how the facility staff kin assessment by only her the skin was intact or ed it was her expectation a full completed weekly with a on of each resident's skin she also recently became atment Nurse was not stand-up meetings where R) were discussed daily. She expectation that the Treatment attended those meetings. The d it was her expectation that sed timely for new or e ulcers and treatments be ed as ordered. Standitted to the facility on ulative diagnoses of Failure (CHF) a fractured fibula saring status, Urinary ral Vascular Disease (PVD)	F	586			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345534	B. WING _				C 15/2018
	ROVIDER OR SUPPLIER	ATION CO		2702	ET ADDRESS, CITY, STATE, ZIP CODE FARRELL ROAD FORD, NC 27330	1 02	10/2010
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	e 34	F	886			
		#2's admission orders dated ordered a skin assessment					
	dated 01/01/18 at 2:4	2's admission nursing note 0 PM did not include any ding his skin condition.					
		2's Interim Care Plan dated ioning every two hours for					
		2's Admission Skin /02/18 read pink area to his o evidence of new orders.					
	assessment documer dated 01/03/18 read a This assessment was	2's new admission skin nated on a shower sheet a pink area to his sacrum. I completed by the ere was no evidence of any					
	read he had the poter related to his recent he in bed from his wheel incontinence. Intervet following: encourage reposition on routine with repositioning as and report any rednes full weekly skin assess skin clean, dry and appreciated to his recent here.	ntions included the					
	Review of Resident #	2's skin assessment					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345534	B. WING _			C 02/15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		02/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	Continued From pag	e 35	F 6	86		
	01/09/18 read pink a assessment was con Nurse. There was no	ower sheet and dated rea to sacrum. This inpleted by the Treatment o evidence of any new orders.				
	(OTA) note dated 01.	/10/18 at 2:12 PM read n breakdown to Resident #2's				
	#2 stated she recalled OTA were in Resider stated she recalled a because his buttocks. She stated Resident	on 02/15/18 at 12:20 PM, NA of the day when she and the at #2's room together. She applying barrier cream as were only red at the time. #2 was on a pressure at had a cushion in his				
	During a telephone interview on 02/15/18 at 12:10 PM, the OTA stated she was in the room with Resident #2 and the NA #2 on 01/10/18 working on his upper body range of motion when she noticed NA #2 putting an ointment on Resident #2's buttocks. She stated she charted that nursing was aware of his skin impairment in her note dated 01/10/18.					
		#2's January 2018 vealed a new order for an theter due to urinary retention				
	PM read the Nursing area to Resident #2's orders to cleanse the wound cleanser, app	Assistant reported open s right and left buttocks. New e right and left buttock with ly Calmoseptine ointment very other day and as				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345534	B. WING _			C 02/15/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CODE	1 02/	10,2010
SANFORD	HEALTH & REHABILITA	ATION CO		2702 FARRE	ELL ROAD		
				SANFORD,	, NC 27330		
(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 B PROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686 Continued From page 36		∋ 36	F 6	86			
		ed the wound communication ed. This note was completed					
	PM, Nurse #1 stated area on Resident #2's completed the wound put a copy in the wou and left a copy for the	tterview on 02/12/18 at 4:50 the aide reported to her an a sacrum on 01/13/18 so she communication form and and communication notebook be Director of Nursing (DON). cted the PA and received					
	open areas to his left sacrum. The shower Director, the Respons Treatment Nurse and	#1 read Resident #2 had and right buttock and sheet indicated the Medical					
	Administration Recor	2's January 2018 Treatment d (TAR) indicated he at as written by Nurse #1's 3/18 with the next treatment					
		2's January 2018 TAR his treatment on 01/15/18 1's nursing note on					
	dated 01/15/18 read was assessed. There	Nurse Consultant note Resident #2's arterial ulcer was no mention of an ent #2's right or left buttocks					
	Review of a nursing r	note dated 01/16/18 at 9:30					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD	NO		(C
		345534	B. WING			02/	15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	FATION CO		270	REET ADDRESS, CITY, STATE, ZIP CODE D2 FARRELL ROAD NFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	The note read on as noted with a stage 3 buttock measuring 7 and 0.2 cm depth. It 80% slough (soft, m and 20% granulatior containing capillaries edges). There was his left buttock measwidth and 0.1 cm de tissue. The note read orders and Resident peri-care and assess note was written by interview on 02/15/1 Nurse stated she was Sunday 01/14/18 and pressure ulcers. She contacted the PA and 01/13/18 so she left wound communicating dated 01/14/18. The evidence of a wound 01/14/18 at the time. Review of Resident read he had stage 3 and left buttocks. Interest following: measure with wound to physicial ordered, use pillows Dietician to evaluate and encourage resident Report dated 01/16/	in for 01/14/18 was conducted. sessment, Resident #2 was pressure ulcer to his right 1.0 cm length, 3.5 cm width was described as having oist avascular dead tissue) in tissue (pink tissue is formed around the wound a stage 3 pressure ulcer to suring 5.0 cm length, 4.7 cm pth with 70% granulation discurrently pending treatment if #2 had a history of refusing isment for incontinence. The incontinence is working at the facility on disassessed Resident #2's is stated Nurse #1 had already discrete discurrently was unable to offer discommunication form dated of exit on 02/15/18. #2's care plan dated 01/16/18 pressure ulcers to his right erventions included the wound weekly, report decline in, administer treatments as a needed, monitor lab-work	F	686			
		e 3 measuring 7.0 cm length					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG	· ,	(X3) DATE SURVEY COMPLETED	
		345534	B. WING			C / 15/2018	
	ROVIDER OR SUPPLIER	LITATION CO		STREET ADDRESS, CITY, STATE, Z 2702 FARRELL ROAD SANFORD, NC 27330		713/2010	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 686	granulation tissue moderate serous of drainage with no contect to his left but 01/14/18. It was domeasuring 5.0 cm cm depth with 70% slough. There was with no odor. The Treatment Nurse and Director was notifit to cleanse right but apply Calmosepting dressing daily and given to cleanse the wound cleanser, a wound bed and Calmoserous contents.	age 38 0.2 cm depth with 60% and 40% slough. There was (body fluids resembling serum) odor. A second new wound was attock was identified on escribed as a stage 3 length, 4.7 cm width and 1.0 of granulation tissue and 30% of moderate serous drainage or report was completed by the and indicated the Medical ed on 01/16/18 with new orders attock with wound cleanser, the and cover with a foam as needed. A new order was the left buttock wound with apply Silver Alginate to the almoseptine to the peri-wound oam dressing daily and as	F	686			
	physician orders of orders for the resident of the resident of 1/16/18. The election of 1/16/18 at 12: entered the follow auto-populated the buttock with woun Calmoseptine and needed. The Silve documented as a Assessment Reposadded to the election appear on the Review of Residenticated no documented no documented as a Assessment Reposadded to the election appear on the Review of Residenticated no documented no documented no documented as a Assessment Reposadded to the election appear on the Review of Residenticated no documented	nt #2's January 2018 written lid not include any treatment dent's pressure ulcers on ctronic medical record indicated 102 PM the Treatment Nurse ing new treatment which e TAR: Cleanse right and left d cleanser, pat dry and apply a foam dressing daily and as er Alginate to the left buttock new order on the Wound out dated 01/16/18 was not ronic medical record and did TAR. Int #2's January 2018 TAR mented initials that his openting with a foam dressing					

NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO SANFORD, NO. 27330 MAID PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO SANFORD, NO. 27330 MAID REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMMENT OF THE PROPERTY TAG F 686 Continued From page 39 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE PREPARA OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE PREPARA OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE PREPARA OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE PREPARA OF THE PREPAR		IND DLAN OF CORRECTION IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVE COMPLETED		
SANFORD HEALTH & REHABILITATION CO (X41) D SUMMARY STATEMENT OF DEFICIENCIES (PADLE DEFICIENCY MUST are PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 686 Continued From page 39 was completed to his right buttocks or any documented initials of his treatment of Calmospetine, Silver Alginate with foam dressing to his left buttocks as written by the Treatment Nurse on the Wound Assessment Report dated on 01/16/18. Review of the acrivine of the daily schedule assignment sheet indicated the Treatment Nurse worked 01/16/18. Review of the daily schedule assignment sheet indicated the Treatment Nurse was a place on his sacrum on 01/13/18 and asked the Wound Ournement Nurse offered no explanation as to why she did not assess it on 01/13/18 and why she was not given a wound communication form until 01/16/18. The Treatment Nurse stated she completed his treatment on 01/16/18 but did not initial it on the TAR. During an interview on 02/12/18 at 3:10 PM, Unit Manager (UM) #2 and the MDS Nurse stated Resident #2 was admitted with no pressure ulcers. UM #2 stated he was up adily with therapy and staff fried to lay him down after funch but sometimes he would refuse. UM #2 and the MDS Nurse recalled on 01/16/18. Unit MDS Nurse the wound measurement obtained by the MDS Nurse on 01/14/18. UM #2 bid the MDS Nurse on 01/14/1			345534	B. WING _				18
FREERIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 686 Continued From page 39 was completed to his right buttocks or any documented initials of his treatment of Calmospetine, Silver Alginate with foam dressing to his left buttocks as written by the Treatment Nurse on the Wound Assessment Report dated on 01/16/18. Review of the archived Time Card Report indicated the Treatment Nurse worked 01/16/18. Review of the daily schedule assignment sheet indicated the Treatment Nurse was assigned all treatments 01/16/18. During an interview on 02/12/18 at 3:30 PM, the Treatment Nurse stated she did not receive the wound communication form dated 01/13/18 until 01/16/18. She stated she was aware there was a place on his sacrum on 01/13/18 and asked the Wound Nurse Consultant to look at it on 01/15/18 but Resident #2 refused to get back into the bed. The Treatment Nurse offered no explanation as to why she did not assess it on 01/13/18 and why she was not given a wound communication form until 01/16/18. The Treatment Nurse stated she completed his treatment on 01/16/18 but did not initial it on the TAR. During an interview on 02/12/18 at 3:10 PM, Unit Manager (UM) #2 and the MDS Nurse stated Resident #2 was admitted with no pressure ulcors. UM #2 stated he was up daily with therapy and staff tried to lay him down after lunch but sometimes he would refuse. UM #2 and the MDS Nurse recalled on 01/16/18 giving the Treatment Nurse the wound measurement obtained by the MDS nurse on 01/14/18. UM #2 told the MDS Nurse recalled on 01/16/18 giving the Treatment Nurse the wound measurement obtained by the MDS nurse on 01/14/18. UM #2 told the MDS Nurse recalled on 01/16/18 giving the Treatment Nurse the wound measurement obtained by the MDS nurse on 01/14/18. Unit #2 and the MDS Nurse recalled on 01/16/18 giving the Treatment Nurse the wound measurement obtained by the MDS nurse on 01/14/18. Unit #2 and the MDS Nurse recalled on 01/16/18 giving the Treatment Nurse the wound measurement obtained by the MDS nurse on 01/14/18.			ATION CO		2702 FARRELL ROAD		02/13/20	10
was completed to his right buttocks or any documented initials of his treatment of Calmospetine, Silver Alginate with foam dressing to his left buttocks as written by the Treatment Nurse on the Wound Assessment Report dated on 01/16/18. Review of the archived Time Card Report indicated the Treatment Nurse worked 01/16/18. Review of the daily schedule assignment sheet indicated the Treatment Nurse was assigned all treatments 01/16/18. During an interview on 02/12/18 at 3:30 PM, the Treatment Nurse stated she did not receive the wound communication form dated 01/13/18 until 01/16/18. She stated she was aware there was a place on his sacrum on 01/13/18 and asked the Wound Nurse Consultant to look at it on 01/15/18 but Resident #2 refused to get back into the bed. The Treatment Nurse offered no explanation as to why she did not assess it on 01/13/18 and why she was not given a wound communication form until 01/16/18. The Treatment Nurse stated she completed his treatment on 01/16/18 but did not initial it on the TAR. During an interview on 02/12/18 at 3:10 PM, Unit Manager (UM) #2 and the MDS Nurse stated Resident #2 was admitted with no pressure ulcers. UM #2 stated he was up daily with therapy and staff tried to lay him down after lunch but sometimes he would refuse. UM #2 and the MDS Nurse recalled on 01/16/18 giving the Treatment Nurse the wound measurement obtained by the MDS nurse on 01/14/18. UM #2 told the	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BE ICED TO THE APPROPRIA	COM	PLETION
Treatment Nurse to ensure the wound nurse consultant observed his sacrum. UM #2 stated she did not assess the pressure ulcers. Review of Resident #2's January 2018 TAR	F 686	was completed to his documented initials of Calmospetine, Silver to his left buttocks as Nurse on the Wound on 01/16/18. Review Report indicated the 01/16/18. Review of assignment sheet indicated the 01/16/18. She stated place on his sacrum Wound Nurse Consult Resident #2 refus to why she did not as she was not given a until 01/16/18. The Treatment Nurse to why she did not as she was not given a until 01/16/18. The Treatment his treatment initial it on the TAR. During an interview of Manager (UM) #2 and Resident #2 was adrulcers. UM #2 stated and staff tried to lay I sometimes he would Nurse recalled on 01 Nurse the wound med MDS nurse on 01/14 Treatment Nurse to econsultant observed she did not assess the state of the state o	a right buttocks or any of his treatment of Alginate with foam dressing a written by the Treatment Assessment Report dated of the archived Time Card Treatment Nurse worked the daily schedule dicated the Treatment Nurse atments 01/16/18. On 02/12/18 at 3:30 PM, the died she did not receive the on form dated 01/13/18 until she was aware there was a on 01/13/18 and asked the Itant to look at it on 01/15/18 are do get back into the bed. Seed to get back into the bed. Seed to get back into the bed. Sees it on 01/13/18 and why wound communication form treatment Nurse stated she ent on 01/16/18 but did not on 02/12/18 at 3:10 PM, Unit d the MDS Nurse stated hitted with no pressure he was up daily with therapy him down after lunch but refuse. UM #2 and the MDS /16/18 giving the Treatment asurement obtained by the ressure the wound nurse his sacrum. UM #2 stated he pressure ulcers.	F	686			

AND DIANIOE CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345534	B. WING _			C 02/15/2018	
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		02/13/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 686	indicated he received dressing daily to his in 01/17/18 through 01/17 receive Silver Algination indicated on the Wood dated 01/16/18. Review of Resident # dated 01/17/18 read supplement used in inthrough nutritional surplement calories Zinc were prescribed for wound healing. Review of Resident # Consultant notes dat buttocks measured 1 and 0.1 cm depth. It excessive necrotic (dissue, yellow in colorand no odor. There were commendations. The staging of Resident # Nurse Consultant. Review of Resident # documented on a shoread his right buttock cm width and 0.1 cm 80% granulation and measured 5.0 cm lend depth with 80% granulation and	I Calmoseptine and a foam right and left buttocks on 25/18. Resident did not e to his left buttock as and Assessment Report. E2's January 2018 orders Prostat (nutritional mproving wound healing pport) and Medpass make that provides and protein), Vitamin C and by the Registered Dietician. E2's Wound Nurse ed 01/22/18 read the area to 5.6 cm length, 10 cm width was described as having ry, scab of dead tissue) r with mild serous drainage were no new orders or there was no documented e2's buttocks by the Wound e2's buttocks by the Wound e2's skin assessment ower sheet dated 01/22/18 measured 6.0 cm length, 3 depth. It was described as 20% slough. The left buttock gth, 4 cm width and 0.1 cm ulation and 20% eschar. Jes in the wound consultant issessment was completed by	F6	586			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345534	B. WING		C 02/15/2018	
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	02/13/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 686	sacrum right and left pat dry then apply S Calcium Alginate and daily and as needed the PA. Review of Resident indicated no docume treatment of Santyl a foam dressing was obuttocks as ordered. Review of the daily sindicated the floor not their own treatments complete Resident # During a telephone in PM, Nurse #3 revea #2's pressure ulcer to ordered but forgot to redered but forgot to Review of Resident indicated he receive Calmoseptine with a and left buttock on 0 Review of a nursing PM, read Resident # difficulty breathing. Review of Resident # difficulty breathing. Review of Resident # difficulty breathing.	new orders to clean his a buttocks with normal saline, antyl (debriding ointment) and docover with a foam dressing. This order was signed by #2's January 2018 TAR ented initials that his and Calcium Alginate with a completed to his right and left on 01/26/18. schedule assignment sheet curses were responsible for a Nurse #3 was assigned to #2's treatment on 01/26/18 at 2:40 led she provided Resident reatment on 01/26/18 as a initial off on the TAR. #2's January 2018 TAR do his treatment of foam dressing to his right	F 68	36		

AND DLAN OF CORRECTION IDENTIFICATION NUMBER			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345534	B. WING			C 02/15/2018	
	ROVIDER OR SUPPLIER D HEALTH & REHABILIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		02/13/2016	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 686	(MRSA) and he was antibiotics. Residen 02/11/18 from a card Review of an anony 01/29/18 read Reside adequate nursing caulcer. The grievance contacted the reside denied knowledge of stated the facility was Attached to the grievance dated 01/29/18 titled given by the Staff Do (SDC). Also attached the in-service. There signature of the Treasin-service roster. During an interview Nursing Assistant (Nowld refuse baths anot want to lay back of the mechanical lift catheter so he was not stool. During an interview DON stated she was a pressure ulcer untand the treatment not stool.	treated with intravenous at #2 expired at the hospital on diac arrest. Imous grievance called in on lent #2 did not receive are resulting in a pressure a read the Social Worker ant representative (RP) who of the call. The Social Worker as investigating the concerns. Invance was in-service agenda at Wound Care Management avevlopment Coordinator d was the staff who attended as was no documented	F 6				
	receive a copy of the completed by Nurse During an interview Treatment Nurse sta	The DON stated she did not e wound communication form #1 dated 01/13/18. on 02/13/18 at 11:10 AM, the ated she began working at the October 2017 but started as a					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		С	
		345534	B. WING			02/	15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILI	TATION CO	•	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	doing treatments a fareatment Nurse stareceived no training previous treatment relack of communication so she instituted a wanotebook and place. When a new area wabout it if the nurses communication note checked the wound daily. The Treatment not have any standitereatments and the pfor new orders where area was noted. She attend morning stanteam and floor staff morning she was but Consultant or working floor nurse call out. During a telephone PM, the Wound Nursessed Resident #2 offloading and she mand no new orders. Stated She only receptacility and it was heaggressive. She state conservatively where She confirmed she is Medical Director or #2's pressure ulcers.	shift. She stated she began few months ago. The ated during that time, she except for two days with the nurse. She stated there was a on from the floor staff to her wound communication done at each nursing station. The wound shook. She stated she communication notebooks to Nurse stated the facility diding orders for pressure ulcer obysician should be contacted in a new area or worsening the stated she did not always drup with the management supervisors. She stated some the sy with the Wound Nurse and on a cart when there for a sinterview on 02/13/18 at 3:10 see Consultant stated she first #2's sacrum on 01/22/18. She was non-complaint with made no recommendations. The Wound Nurse Consultant tently started coming to the per practice not to be overly ted she chose to act in treating pressure ulcers. The part of t	F	686			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		345534	B. WING _			C 02/15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		02/10/2010
(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 CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 686	available after hours was not involved in was not involved in was not involved in was not involved in was aware addressed and the Wound Nurs was aware Resident but was unsure of the someone calling her nurse orders but was. The Medical Director telephone interview of stated he was unaway Wound Care Manage several weeks ago, impression the Wourfollowing all residents stated he was not away a pressure ulcer to her Resident #2 was being and the was not in Resident #2 was being and the was not in Resident #2 was being was a pressure ulcer to her was not in Resident #2 was being was a pressure ulcer to her was not in Resident #2 was being was a was a pressure ulcer to her was not away a pressure ulcer to her was not in Resident #2 was being was a was	Monday through Friday and by phone. She stated she yound care and any pressure ed by the Treatment Nurse e Consultant. She stated she #2 developed a sacral ulcer e onset date. The PA recalled for orders and she gave the aunsure of the date. was interviewed via on 02/13/18 at 5:15 PM. He are until recently of the new ement providers who started He stated he was under and Nurse Consultant was a with pressure ulcers. He ware Resident #2 developed	F			
	been contacted with #2's pressure ulcer. it was his expectation worsening pressure treatment orders obtable completed as ordestated there seemed communication on the During an Interview of Administrator stated orders for new or worsther the nurse was physician each time stated when an orderattending physician,	ained timely and treatments ered. The Medical Director to be a lack of reaction and e part of the facility. on 2/14/18 at 9:50 AM, the the facility had no standing resening pressure ulcers but to notify the responsible for specific orders. She				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI			, ا	C
		345534	B. WING				15/2018
	ROVIDER OR SUPPLIER DHEALTH & REHABIL	TATION CO		2702	EET ADDRESS, CITY, STATE, ZIP CODE FARRELL ROAD FORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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 686	prescriber's signature electronic medical restated nothing showelectronic medical restated nothing showelectronic medical restated nothing showelectronic medical restated. She stated she was still of concerns related performing her dutive became evident are inclement weather. (UM) brought it to the Administrator. She a full body inspection narrative descriptions status. She stated saware that the Treattending morning spatients at risk (PAI stated it was her examples and stated it was her examples and followed the Administrator stated residents be assess worsening pressure initiated and followed. The Administrator provided and followed. Resident#1 and Resident#1 and Resident#1 and Resident#1 and Resident residents in unitial states of providers; nursing states of the facility. There was a lack of providers; nursing states of the facility. There was a lack of providers; nursing states of the facility.	er be written with the re then entered into the record. The Administrator ald be entered into the record unless there was a stated she took over as the ron 02/12/18 and prior to an interim Administrator. She involved and had knowledge to the Treatment Nurse not res. The Administrator stated it bund mid-January 2018 during She stated the Unit Managers he attention interim stated it was her expectation on be completed weekly with a nof each resident's skin she also recently became them Nurse was not stand-up meetings where record in the preciation that the Treatment restended those meetings. The dit was her expectation that seed timely for new or a ulcers and treatments be red as ordered.	F	586			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345534	B. WING_			C 02/15/2018	
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		32/13/2016	
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 686	being provided as ord the treatment nurse to ordered by the physical The Treatment Nurse completing treatment initiated. Floor staff of beginning 2/14/18 unretraining is completed. A 100% of all current facility received a hear initiated on 2/13/18 at 2/14/18 by the Unit Moevelopment Coordin Nursing to identify and Three new concerns attending provider was initiated as ordered at Treatment Administrative Wound Communication Responsible Representation of Treatment Staff Development verify all treatments of corresponding physical was transcribed as on the Wound Consultative treatment changes we provider upon receiptions.	there was a treatment not dered due to the failure of complete treatments as cian. was removed from so 2/14/18 and retraining will complete treatments till the Treatment Nurse's ed. tresidents residing the ad to toe skin audit that was not was completed on lanagers x 2, Staff mator, and Director of by unreported skin concerns. were identified, the as notified and treatment and documented on the ation Record, entered the con Book, and the centative was notified. It ment Administration and the ded with physician's orders by the Unit Managers x 2 and and to coordinator on 2/15/18 to on the TAR have cian's order and the order	F 6	86			
		Unit Manager. All orders will e attending provider's transment Nurse or Unit					

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		ATE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 686 Continued From page 47 Manager. The Staff Development Coordinator initiated an in-service on 2/15/18 to 100% of all nursing assistants on reporting skin changes noted during care by completing a full body shower sheet and submitting the sheet to the Charge Nurse. The Charge Nurse will observe the resident's skin, notify the physician for treatment Administration Record, initiate the treatment, and notify the Responsible Representative. The Charge Nurse will enter the resident and the skin issue in the Wound Communication Book for the Treatment Nurse to review and follow. The completed shower sheet will be given to the Unit			345534	B. WING			_
F 686 Continued From page 47 Manager. The Staff Development Coordinator initiated an in-service on 2/15/18 to 100% of all nursing assistants on reporting skin changes noted during care by completing a full body shower sheet and submitting the sheet to the Charge Nurse. The Charge Nurse will observe the resident's skin, notify the physician for treatment Administration Record, initiate the treatment, and notify the Responsible Representative. The Charge Nurse will enter the resident and the skin issue in the Wound Communication Book for the Treatment Nurse to review and follow. The completed shower sheet will be given to the Unit					2702 FARRELL ROAD		J2/19/2016
Manager. The Staff Development Coordinator initiated an in-service on 2/15/18 to 100% of all nursing assistants on reporting skin changes noted during care by completing a full body shower sheet and submitting the sheet to the Charge Nurse. The Charge Nurse will observe the resident's skin, notify the physician for treatment orders, transcribe the order to the Treatment Administration Record, initiate the treatment, and notify the Responsible Representative. The Charge Nurse will enter the resident and the skin issue in the Wound Communication Book for the Treatment Nurse to review and follow. The completed shower sheet will be given to the Unit	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
been completed. The Staff Development Coordinator initiated an in-service on 2/14/18 to 100% of all licensed staff to complete admission/re-admission head to toe skin assessments and weekly head to toe skin assessments with documentation of the assessment in the electronic medical record. The in-service included what to do when a new skin issue is identified and notification to the MD, Resident Representative, Treatment Nurse, and Unit Managers. All newly hired nursing staff will receive the appropriate education during orientation. No staff will work until the in-service is completed. Utilizing a Treatment Record Administration QI Audit Tool, the Staff Development Coordinator will review 100% of all treatment records to assure the treatments have been completed and signed	F 686	Manager. The Staff Developm in-service on 2/15/1 assistants on report care by completing submitting the sheet Charge Nurse will onotify the physician transcribe the order Administration Reconotify the Responsit Charge Nurse will eissue in the Wound Treatment Nurse to completed shower some Manager to verify albeen completed. The Staff Developm in-service on 2/14/1 to complete admissis skin assessments a assessments with dassessment in the ein-service included vissue is identified and Resident Represent Unit Managers. All receive the appropriorientation. No staff is completed. Utilizing a Treatmen Audit Tool, the Staff review 100% of all to	ent Coordinator initiated an 8 to 100% of all nursing ing skin changes noted during a full body shower sheet and to the Charge Nurse. The bserve the resident's skin, for treatment orders, to the Treatment ord, initiate the treatment, and ole Representative. The inter the resident and the skin Communication Book for the review and follow. The sheet will be given to the Unit I phases of the process have ent Coordinator initiated an 8 to 100% of all licensed staff on/re-admission head to toe and weekly head to toe skin ocumentation of the electronic medical record. The what to do when a new skin and notification to the MD, sative, Treatment Nurse, and newly hired nursing staff will ate education during f will work until the in-service It Record Administration QI Development Coordinator will reatment records to assure	F 6	86		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345534	B. WING				C 45/2048		
	ROVIDER OR SUPPLIER DHEALTH & REHABILITA			STREET ADDRESS, CITY, STATE, ZIP 2702 FARRELL ROAD SANFORD, NC 27330	CODE	<u> U2/</u>	15/2018		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 686	weeks, then weekly x month. Utilizing a W (WAM) QI Audit Tool, Coordinator will compall wounds are docun all parts of an assess have been completed occur weekly x 8 wee an Admissions Wound Managers will review admission/re-admissi assessment was company identified skin isstreatment order, prog MD and Resident Repotification was company identification was compound and Resident Repotification was compounded to the Communication book will review the QI Audit monthly x 1 for trends. The Director of Nursing the monitoring to the Committee monthly x concerns, and recommodification of the profile of the profile of the Staff Development Complysician order procedunderstand that if we attending physician of Medical Director is refacility staff orders for wound care orders.	ound Assessment Manager the Staff Development olete a record review to verify mented in the WAM to assure ment for 100% of wounds I weekly. Monitoring will oks, then monthly x 1. Using d QI Tool, the Unit all new on records to assure a skin upleted on admission and use were addressed with a ress note, notification to the presentative was made, and oleted in the Wound. The Director of Nursing lit Tools weekly x 8, then and concerns. In g will report the results of Quality Assurance 3 months for trends, mendations for any occess Physicians and Physician educated on 2/14/18 by the pordinator regarding the less. All physicians are unable to locate the resident. This includes otherwise, all physicians and esponsible for giving orders	F	686					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345534	B. WING		C 02/15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILITA		;	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	02/19/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.475
F 686 F 727 SS=E	implementing the according on 2/15/18, date of results on 2/15/18, date of results on 2/15/18, date of results of the credible allegation at 5:00 PM as eviden regarding skin assess pressure ulcers, worse actions to take immedin-house acquired preworsened. Review of revealed licensed and the facility received trhave the in-servicing working on the floor. RN 8 Hrs/7 days/Wk, CFR(s): 483.35(b)(1): §483.35(b)(1): Except paragraph (e) or (f) or must use the services least 8 consecutive him services least 8 consecutive him services director of nursing on \$483.35(b)(3) The director of nursing on average daily occupant this REQUIREMENT by: Based on record revisable of the control	eptable plan of correction amoval 2/15/18. In was verified on 02/15/18 ce by staff interviews on sments, identification of new tening of pressures and diately when a newly essure ulcer identified or on-going in-service records dividence and staff who did not would be in-serviced prior to Full Time DON (3) If this section, the facility is of a registered nurse for at ours a day, 7 days a week. When waived under if this section, the facility istered nurse to serve as the a full time basis. The correction of the facility has an oncy of 60 or fewer residents. The is not met as evidenced items and staff interview, the facile a Registered Nurse on secutive hours a day for 6	F 686	The Facility was unable to correct pas staffing postings.	
	of the past 30 days re 1/25/18, 1/31/18, 2/12	eviewed (1/15/18, 1/22/18, 2/18 and 2/13/18).		The facility failed to ensure a minimum 8 consecutive hours of RN coverage polynomials.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		e) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING			02/	C 15/2018	
	ROVIDER OR SUPPLIER DHEALTH & REHABILITA			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 727	past 30 days was cordily Schedules indic (RN) was not schedule hours a day on the form 1/22/18, 1/25/18, 1/3 An interview was condered with the facility is interview, inquiry was hours indicated on the Administrator reported coverage was a probeomismed there were coverage was provided expectation was, the would expect to be interview.	l: y's Daily Schedules for the inducted on 2/15/18. The stated a Registered Nurse led for at least 8 consecutive llowing dates: 1/15/18, 1/18, 2/12/18 and 2/13/18. ducted on 2/15/18 at 12:55 and Administrator. During the staffing schedule. The dishe was aware RN lem at the facility and some days where no RN led. When asked what her Administrator stated she compliance with the we at least 8 consecutive	F	d To a a a re To re a m TA 2 sip 2 ci ci d UA A waa ci w th w D w o	the Administrator initiated an in-service on 2/19/18 to the Staffing Coordinator of lert the Director of Nursing in advance only days when the RN coverage equirement is not met. The Administrator initiated an in-service on 2/19/18 to the Director of Nursing to eview the working schedule in advance source the RN coverage requirement is net. The Administrator contacted the Executassistant of the Corporate Office on 1/15/18 to post an advertisement with a pecific job seekers internet site for RN ositions. Corrective action completed 1/26/18 included adjusting schedules of current RNs in the facility to assure 8 consecutive hours of RN coverage per ay, seven days per week. Itilizing a Staff Posting accuracy/Verification of RN Hours QI audit Tool, the Human Resources Directification of RN Hours QI audit Tool, the Human Resources Directification of RN Hours QI audit Tool, the Human Resources Directification of RN Hours QI audit Tool, the Human Resources Directification of RN Hours QI audit Tool, the Human Resources Directification of RN Hours QI audit Tool, the Human Resources Directification of RN Hours QI audit Tool, the Human Resources Directification of RN Hours QI audit Tool, the Human Resources Directification of RN Hours QI audit Tool, the Human Resources Directification of RN Hours QI audit Tool, the Human Resources Directification of RN Hours QI audit Tool, the Human Resources Director will audit the staff posting 2 time feekends. Then, the Human Resources Director will audit the weekend posting x 1 aveekend. Then monitoring will continuance weekly x 8 weeks and 1 weekend months. The Administrator will review months. The Administrator will review months. The Administrator will review months.	e of e of e of e of e of e of c of e		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345534	B. WING			1	C
	ROVIDER OR SUPPLIER HEALTH & REHABILITA			270	REET ADDRESS, CITY, STATE, ZIP CODE 2 FARRELL ROAD NFORD, NC 27330	02/	15/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO 1		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
	must post the following basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categoral unlicensed nursing stresident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must per second control of the facility mu	g Information -(4) affing Information. equirements. The facility ng information on a daily and the actual hours worked gories of licensed and aff directly responsible for t: s. I nurses or licensed defined under State law). des. g requirements. ost the nurse staffing data h (g)(1) of this section on a inning of each shift. ted as follows:	F 7		and initial the Audit tool weekly x 12 weeks for trends and concerns. The Administrator will present the finding of the audits to the Quality Assurance Performance Improvement Committee monthly x 3 months for trends and the need for continued monitoring and recommendations for any modification the process. The Administrator is responsible for implementing the plan of correction.		2/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345534	B. WING _		0.	C 2/15/2018	
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	2/13/2010	
				2702 FARRELL ROAD			
SANFORD	HEALTH & REHABILITA	ATION CO		SANFORD, NC 27330			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 732	F 732 Continued From page 52		F 7	32			
	(B) In a prominent pla residents and visitors	ace readily accessible to					
	staffing data. The factoristic written request, make	c for review at a cost not to					
	§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced						
	facility failed to post a information for 14 of 1/15/18, 1/16/18, 1/2 1/26/18, 1/27/18, 1/2	iews and staff interviews, the accurate nurse staffing the past 30 days (1/14/18, 1/18, 1/22/18, 1/25/18, 1/31/18, 2/1/18, 2/6/18, 1/31/18, 2/1/18, 2/6/18,		The Daily facility staff posting f was corrected by the reception posted in the Main Lobby of the The facility utilized an excel spr	ist and e facility. readsheet		
	staffing information fr	l: y's daily posts for nurse om the past 30 days was		to calculate staffing hours base number of staff members worki shift. The formula used in the e spreadsheet for the posting of shours used by the facility was in The Receptionist failed to assu	ing per excel staffing naccurate. re the		
	included an inaccurar worked by Registered last 30 days, which inOn 1/14/18, 1 RN w AM to 7:00 PM shift a on the 7:00 PM to 7:0 number of hours work reported to be 12 hoursOn 1/15/18, no RNs AM to 7:00 PM shift of	rorked 12 hours on the 7:00 and 1 RN worked 12 hours 00 AM shift. The total ked by RNs on this date was		corrective action was complete 2/26/18 by implementing a new posting sheet that does not use for calculating hours. 100% of Receptionists received an in-se beginning 2/19/18 by the Admir assure the daily staff posting waccurately updated and posted at the beginning of the work danewly hired receptionists will be	ed on y staff e formulas ervice histrator to as each day y. All		

PRINTED: 03/19/2018 FORM APPROVED

CENTER	S FUR MEDICARE &	MEDICAID SERVICES			OMB I	NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	' '	TE SURVEY MPLETED
		345534	B. WING			C)2/15/2018
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2702 FARRELL ROAD		
SANFORE	HEALTH & REHABILITA	ATION CO		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 732	on this date was reported to be 12 hours worked by R reported to be 12 hours worked to be 12 hours on the 7:00 PM to 7:00 PM shift. The total numb on this date was reported to be 12 hours on 1/25/18, no RNs AM to 7:00 PM shift of shift. The total numb on this date was reported to be 12 hours on 1/26/18, 1 RN w AM to 7:00 PM shift aduring the 7:00 PM shift aduring the 7:00 PM shift aduring the 7:00 PM shift, the 7:00 PM to 7:00 PM shift, the 7:00 PM to 7:00 PM shift, the 7:00 PM to 7:00 PM to 7:00 PM to 7:00 PM to 7:00 PM hours on the 7:00 PM number of hours work reported to be 12 hours on the 7:00 PM number of hours work reported to be 12 hours on 1/28/18, 1 RN worked to 1/28/18,	orked 8 hours during the shift and no RNs worked on M shift. The total number Ns on this date was ars. worked 12 hours each on PM shift and no RNs worked 10 AM shift. The total ked by RNs on this date was ars. worked on either the 7:00 or on the 7:00 PM to 7:00 AM er of hours worked by RNs arted to be 12 hours. worked on either the 7:00 or on the 7:00 PM to 7:00 AM er of hours worked by RNs arted to be 12 hours. worked on either the 7:00 or on the 7:00 PM to 7:00 AM er of hours worked by RNs arted to be 12 hours. orked 12 hours on the 7:00 and 1 RN worked 8 hours or 7:00 AM shift. The total ked by RNs on this date was ars. orked 12 hours on the 7:00 AM shift and 1 RN worked 12 to 7:00 AM shift. The total ked by RNs on this date was ars. orked 12 hours on the 7:00 AM shift. The total ked by RNs on this date was ars. orked 12 hours on the 7:00 AM shift. The total ked by RNs on this date was ars. orked 12 hours on the 7:00 AM shift. The total ked by RNs on this date was ars.	F 73	<u> </u>	eir shift. rs QI s Director ccurate gger on ach he audit the s 2 / will audit d. Then ekly x 8 as. The al the trends e findings ance mittee ad cation of	
	AM to 7:00 PM shift a on the 7:00 PM to 7:0 number of hours work reported to be 12 hou On 1/31/18, no RNs AM to 7:00 PM shift of	and 1 RN worked 12 hours 0 AM shift. The total and by RNs on this date was				

on this date was reported to be 12 hours.

AND DUAN OF CODDECTION INDENTIFICATION NUMBER.		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345534	B. WING		02/4	
	ROVIDER OR SUPPLIER HEALTH & REHABILIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	1 021	15/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 732	On 2/1/18, 1 RN w AM to 7:00 PM shift on the 7:00 PM to 7: number of hours wo reported to be 12 hoOn 2/6/18, 1 RN w AM to 7:00 PM shift on the 7:00 PM shift shift. The total numl on this date was repOn 2/13/18, no RN AM to 7:00 PM shift shift. The total numl on this date was repOn 2/13/18, no RN AM to 7:00 PM shift shift. The total numl on this date was repOn 2/13/18, no RN AM to 7:00 PM shift shift. The total numl on this date was repOn 2/13/18, no RN AM to 7:00 PM shift shift. The total numl on this date was repOn 2/13/18, no RN AM to 7:00 PM shift shift. The total numl on this date was repOn 2/13/18, no RN AM to 7:00 PM shift shift. The total numl on this date was repOn 2/13/18, no RN AM interview was co PM with the facility ' interview, the Administrator sta daily nurse staff positing the Administrator sta daily nurse staff positing staffing information. she received the nur facility 's scheduler information provided	orked 12 hours on the 7:00 and 1 RN worked 12 hours 00 AM shift. The total ked by RNs on this date was urs. Orked 12 hours on the 7:00 and 1 RN worked 12 hours 00 AM shift. The total ked by RNs on this date was urs. So worked on either the 7:00 or on the 7:00 PM to 7:00 AM over of hours worked by RNs orted to be 12 hours. So worked on either the 7:00 or on the 7:00 PM to 7:00 AM over of hours worked by RNs orted to be 12 hours. So worked on either the 7:00 or on the 7:00 PM to 7:00 AM over of hours worked by RNs orted to be 12 hours. Inducted on 2/15/18 at 12:55 as Administrator. During the distrator reported this was hereful the facility. Upon review of the facility. Upon review of the facility. Upon review of the facility were errors in the total ours reported for Registered distraction was, atted she would expect the things to be accurate. Inducted on 2/15/18 at 4:14 as receptionist. During the distraction of the facility of the facility. The receptionist reported sing schedule from the	F 73			

PRINTED: 03/19/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345534	B. WING			C / 15/2018	
NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITA	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	, ,		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIT DEFICIENCY)) BE	(X5) COMPLETION DATE	
reported that when the spreadsheet was revit was discovered it he number "12," resucoverage being reports he stated no one has spreadsheet until now Residents are Free of CFR(s): 483.45(f)(2) The facility must ensugh 483.45(f)(2) Resident medication errors. This REQUIREMENT by: Based on staff and Frecord review, the fact antibiotic as ordered tract Infection (UTI), does and a significant (Resident #2) of 3 resumed to the findings included Resident #2 was admicumulative diagnoses (CHF) a fractured fibrustatus, Urinary Retending Disease (PVD) and Extending Resident #2's admissing indicated severe cognicoded as requiring extoileting and hygiene incontinent of bladders.	posting. The receptionist be template for the liewed earlier this afternoon, ad been pre-populated with alting in 12 total hours of RN red each day on the posting. It do noticed the error on the w. If Significant Med Errors The is not met as evidenced Pharmacist interviews and collity failed to administer an for the treatment of a Urinary This resulted in 3 missed at omission in orders for 1 sidents reviewed for UTI's. It: Initted 01/01/18 with a of Congestive Heart Failure alla with non-weight-bearing atton, Peripheral Vascular Dementia without behaviors. Is in MDS dated 01/08/18 anitive impairment. He was stensive assistance with Resident #2 was coded as	F 7		t dose ed by le d not e so or did e urse ating port to did	2/26/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345534	B. WING			C 02/15/2018	
	ROVIDER OR SUPPLIER HEALTH & REHABILIT.	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CO 2702 FARRELL ROAD SANFORD, NC 27330	DE .	22.10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 760	incontinence. The CA would be developed. Review of nursing not AM read Resident #2 sample to rule out a confusion. Review of Resident # orders revealed a nean indwelling urinary Retention. Review of Resident # read he had an indwelling urinary retention. He symptoms of UTI's the Interventions include assessment for sympabnormal findings to assessment of the confusion. Review of a urine culto 1/12/18 read Reside Enterococcus (e-coli by the Physician Assemitten for Ampicillin mouth every six hour Review of Resident # Medication Administr	the dated 01/08/18 at 12:14 2 was catharized for a urine UTI due to increased #2's January 2018 physician w order dated 01/10/18 for catheter due to Urinary #2's care plan dated 01/10/18 elling urinary catheter due to was to exhibit no signs or arough the next review. d the following: ongoing btoms of an UTI, report the physician and ongoing olor, clarity and character of ture final report dated ent #2 had a UTI positive for b. The report was reviewed istant (PA) and orders were (an antibiotic) to be given by s for seven days. #2's January 2018 ation Record (MAR) read his	F 76		ailable to ugh the orify the is not cluded that or omitted Corrective 26/18 based with 100% of why hired enducation Audit Tool, dinator and with the cords for the assure the concerns will at the time of cur Monday en twice kly x 4 weeks, send endication enducation enducatio		
	the nursing note read pyxis (automated me	n ordered was not 3/18 at 6:00 AM. Review of If the Ampicillin was not in the Idication dispensing system) In delivered by the pharmacy.		results of the monitoring at n Quality Assurance Quality In Committee meeting X 3 mon and recommendations for ar modification of the process.	nprovement of the for trends		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING				C 15/2018	
NAME OF P	ROVIDER OR SUPPLIER	0.000		STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 02/	15/2016	
	10 113 211 011 001 1 21211				02 FARRELL ROAD			
SANFORD	HEALTH & REHABILITA	ATION CO		SANFORD, NC 27330				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 760	Continued From page	e 57	F 70	60				
	Review of Resident # indicated Ampicillin w administered on 01/1 6:00 AM. Review of the Nurse # 5 revealed the review of the rev	2's January 2018 MAR			The Administrator is responsible for implementing the plan of correction.			
	Reference informatio before 7:00 PM will b Orders received after next business day. No medications or STAT after 7:00 PM, should	acy provider undated Quick in read "orders received e delivered the same day. 7:00 PM, will be deliver the ew orders, emergency (immediate) orders needed I be obtained from the First) if available or called into y."						
	Nurse # 4 stated she Ampicillin was not in should have contacte of 01/12/18 when she	on 02/14/18 at 2:50 PM, was not aware that the pyxis inventory and she ad the pharmacy the evening e received the order to tarted timely treatment for						
	Nurse #5 stated it was change on 01/16/18 to pending on Resident not administer his 12. Ampicillin doses on 0 not look at the medical	on 02/14/18 at 3:00 PM, s reported to her during shift hat the results were still #2's urinalysis so she did :00 AM and 6:00 AM 1/17/18. She stated she did al record and did not contact olding his antibiotic for two						
	Pharmacy Technician	on 02/15/18 at 3:00 PM, the stated the order was faxed 0 PM and was not ordered						

PRINTED: 03/19/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345534	B. WING			1	C 15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CO	1	STREET ADDRESS, CITY, S 2702 FARRELL ROAD SANFORD, NC 27330	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORR	C'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760 F 842 SS=D	the evening medication facility did not contact pharmacy delivery. Telephone interview of Consultant Pharmacismissed doses on 01/r of Resident #2's schetthis was considered a antibiotic treatment of Interview on 2/14/18. Administrator stated in Resident #2 would have ordered. Resident Records - Io CFR(s): 483.20(f)(5),	ras delivered 01/13/18 with on delivery. She stated the the pharmacy for back-up on 02/15 at 3:10 PM, the st stated since the two 17/18 occurred in the middle eduled administration days, a significant omission in his orders. at 9:50 AM, the the was her expectation that have received his antibiotic as dentifiable Information 483.70(i)(1)-(5)		760 342			2/26/18
	(i) A facility may not resident-identifiable to (ii) The facility may reresident-identifiable to accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical re §483.70(i)(1) In accorprofessional standard	elease information that is of an agent only in intract under which the agent disclose the information the facility itself is permitted accords. Indicate with accepted and practices, the facility all records on each resident ented; eented; e; and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345534	B. WING		02	C / 15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILITA			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	02	119/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 842	§483.70(i)(2) The fac all information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, par operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic vactivities, judicial and law enforcement purp purposes, research pmedical examiners, for a serious threat to he by and in compliance §483.70(i)(3) The fac record information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirement.	ility must keep confidential ned in the resident's records, in or storage method of the release is- ir their resident permitted by applicable law; in or health care ted by and in compliance ted by and in compliance is activities, reporting of abuse, violence, health oversight administrative proceedings, administrative proceedings, activities, or to coroners, uneral directors, and to avertallth or safety as permitted with 45 CFR 164.512. Ility must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when int in State law; or ars after a resident reaches	F 84	<u> </u>		
	(i) Sufficient informati (ii) A record of the res (iii) The comprehensi provided;	dical record must contain- on to identify the resident; sident's assessments; we plan of care and services of preadmission screening				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
		345534	B. WING			C 2/15/2018
NAME OF P	ROVIDER OR SUPPLIER	0.0001	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CC		2/15/2016
NAME OF T	TOVIDER OR OUT FEIER			2702 FARRELL ROAD	DL .	
SANFORD	HEALTH & REHABI	LITATION CO		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 842	Continued From p	age 60	F 8	342		
	and resident revie	w evaluations and				
		nducted by the State;				
		rse's, and other licensed				
	professional's prog					
	(vi) Laboratory, rad	diology and other diagnostic				
	services reports as	s required under §483.50.				
	· ·	NT is not met as evidenced				
	by:					
		nysician, physician assistant,		Resident #1 and Resident #	£2 no longer	
		sultant interviews and record		reside in the facility.		
		failed to maintain complete and records as evidenced by		The Treatment Nurse failed	to correctly	
		treatment orders without		date wound assessments er	,	
		sian #1 for Resident #1. The		Wound Assessment Report.		
		o provide documented		Treatment Nurse, Nurse #1,		
	_	t #1's treatments were		failed to electronically sign the		
	administered as o	rdered and failed to provide		Administration Record after		
	documented evide	nce that Resident #1 received		each treatment on Resident	#1. The	
	pressure ulcer trea	atments 01/16/18, 01/18/18,		Treatment Nurse and Nurse	s #3 failed to	
		3 and 01/24/18. The facility		electronically sign the Treatr		
	_	physician approval before		Administration Record after		
		nt for the pressure ulcer for		each treatment on Resident	-	
		ailed to provide documented		Treatment Nurse failed to as		
		ident #2's treatments were		written treatment orders with	•	
		ed by the physician. This was dent #1 and Resident #2) of 4		signature prior to entering or electronic health record.	ders into the	
		d for pressure ulcers.		electionic nealth record.		
		a for procedure dicere.		The Treatment Nurse was re	emoved from	
	The findings include	ded:		completing treatments 2/14/		
				retraining initiated. Floor sta		
	1. Resident #1 wa	s admitted to the facility on		complete treatments beginn		
		ulative diagnoses of		until the Treatment Nurse □s	-	
		se, Peripheral Vascular		completed. The Charge Nu		
		ia and Benign Hypertrophic		responsible for providing wo		
	Prostrate with an i	ndwelling urinary catheter.		treatments in the event the		
				Nurse is absent from work o	r assigned	
		nt #1's Wound Assessment		other duties.		
		9/18 read Resident #1 was		The Administrat		
	admitted with unst	ageable pressure ulcers to his		The Administrator re-educat	ea tne	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						С	
		345534	B. WING _			02/	15/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CANEODO	LIEALTH O DELIADILIT	ATION CO		27	702 FARRELL ROAD		
SANFURD	HEALTH & REHABILITA	ATION CO		S	ANFORD, NC 27330		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 842	Continued From page	e 61	F 8	342			
	· -	, and left buttock. The	' '		Treatment Nurse on 2/16/18 on the		
		by the Treatment Nurse			expectations of documentation. The		
		an #1 was notified on			Treatment Nurse returned to the floor		
	01/09/18 with treatme				completing treatments on 2/17/18. All		
	o 17007 To With trouting	one ordere periang.			newly hired treatment nurses will receive	ve	
	During an interview o	n 2/14/18 at 12:05 PM, the			the education during orientation.	, ,	
	_	ed she was not made aware			and daddation daring onlinetion.		
		s found on Resident #1 until			A 100% audit of Treatment Administrati	ion	
		stioned regarding the Wound			Records were reviewed with physician		
		she completed on 01/09/18			orders for the past 30 days by the Unit		
	-	reatment Nurse stated she			Managers x 2 and the Staff Developme		
		assessment incorrectly and			Coordinator on 2/15/18 to verify all		
	it should have been d				treatments on the TAR have		
	Treatment Nurse stat	ed when she found out			corresponding physician □s order and t	he	
	about Resident #1's p	pressure ulcers on 01/12/18,			order was transcribed as ordered with	no	
	she notified Physiciar	n Assistant #1 (PA) who gave			issues identified. All treatments		
	her the original treatn	nent orders entered in the			transcribed on the TAR had		
	electronic record date	ed 01/12/18 but she must			corresponding treatment orders and we	ere	
	have forgotten to writ	e an original physician order.			correctly transcribed as ordered.		
					The Wound Consultant will begin writin	•	
		nic physician orders dated			her own treatment orders as of 2/14/18		
	0 =	I was conducted. The			while in the facility after her assessmen		
		ered the following new			of the wound. The Wound Consult Re	oort	
		ch auto-populated the TAR:			will be reviewed with the provider. All	ĺ	
	bilateral buttocks and				orders will be transcribed by the		
		cleanser, patted dry and			Treatment Nurse or Charge Nurse.		
	-	ent (analgesic, antiseptic,			The Staff Davidsonment Coordinator		
		protectant combination) was			The Staff Development Coordinator initiated an in-service on 2/14/18 to 100	ገ0/ ₋	
	to be applied to the p	obial, highly absorbent			of all licensed staff on timely and accur		
		ionic silver) to the wound			documentation of treatments. Corrective		
	_	ered with a protective foam			action was completed on 2/26/18 follow	-	
		needed. There were no			completion of all in-servicing.	nig	
	written physician orde				Completion of all III-servicing.	ĺ	
		nic physician orders dated			Utilizing a Treatment Record	ĺ	
		revealed the Treatment			Administration QI Audit Tool, the Direct	or	
	·	lowing new treatment which			of Nursing and Staff Development	Oi	
		AR: cleanse Resident #1's			Coordinator will review 100% of all		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	` ′	TE SURVEY MPLETED
		345534	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	040004		6.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	2/15/2018
NAME OF T	NOVIDEN ON 3011 EIEN				702 FARRELL ROAD		
SANFORE	HEALTH & REHABI	LITATION CO					
				5	SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 842	Continued From p	page 62	F 8	342			
	T	nd to his sacrum with Anasept			treatment records to assure the		
	_	microbial wound cleanser with			treatments have been completed and		
		actericidal properties) for odor			signed off by the staff. Monitoring will		
		ea dry and apply Calmoseptine			occur Monday through Friday x 2 week		
		then apply Calcium Alginate to			then twice weekly x 2 weeks, then wee		
		ly. Cover with a foam dressing			x 4 weeks, then monthly x 1 month. T	-	
	daily and as need	ed. There were no written			Director of Nursing will review the QI A		
	physician orders f	or this treatment.			Tool weekly x 8, then monthly x 1 for		
					trends and concerns.		
		nt #1's January 2018 TAR					
		mented initials that his			The Director of Nursing will report the		
		npleted to his sacrum on			results of the monitoring to the Quality		
		of the archived Time Card			Assurance Committee monthly x 3		
		he Treatment Nurse worked			months for trends, concerns, and	- c	
		of the daily schedule			recommendations for any modification	OT	
	1 -	indicated the Treatment Nurse lo all treatments 01/16/18.			the process		
	was assigned to c	io ali treatments o 1/10/10.			The Administrator is responsible for		
	During an intervie	w on 2/14/18 at 12:05 PM, the			implementing the plan of correction.		
	_	stated that, regarding the			implementing the plan of correction.		
		ysician order for treatment					
		8, the Wound Nurse Consultant					
	_	ders on 01/15/18 but the					
	Wound Nurse Cor	nsultant was responsible for					
		eatment orders. The Treatment					
		only entered the new treatment					
		tronic medical record on					
		er saw an original written order.					
		ust have inaccurately entered					
	the orders given b	y the Wound Nurse Consultant.					
	During a talanhan	e interview on 02/14/18 at 4:10					
		onsultant Nurse stated she first					
	1 '	nt #1 on 01/15/18 and gave new					
		oney and Calcium Alginate to all					
		um. She stated it was her					
		ne order she gave to the					
	· •	on 01/15/18 would have been					
	written and impler						

AND DI AN OF CORRECTION INTERPRETATION NUMBERS		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345534	B. WING		C 02/15/2018
	ROVIDER OR SUPPLIER	FATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	1 02/10/2010
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 842		#1's January 2018 TAR	F 84	2	
	of the daily schedule the floor nurses wer treatments on 01/18	ented initials that his eleted to his sacrum. Review e assignment sheet indicated e responsible for their own /18. Nurse #1 was assigned ht #1's treatment on 01/18/18.			
	AM, Nurse #1 stated	interview on 02/12/18 at 11:30 d she completed the 18 but must have forgotten to			
	indicated no document treatment was compounded to the compound of the compound	#1's January 2018 TAR ented initials that his eleted to his sacrum on f the archived Time Card Treatment Nurse worked f the daily schedule dicated the Treatment Nurse treatments on 01/19/18.			
	indicated no docume treatment was comp 01/23/18. Review o Report indicated the 01/23/18. Review o	dicated the Treatment Nurse			
	Treatment Nurse sta missing documentat TAR, she stated she	on 2/14/18 at 12:05 PM, the ated that, regarding all the ion for treatments on the must have forgotten to initial at #1 received his treatments 18 and 01/23/18.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345534	B. WING		C 02/15/2018	
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT	TATION CO	2	TREET ADDRESS, CITY, STATE, ZIP CODE 702 FARRELL ROAD SANFORD, NC 27330	, 02.10.2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 842	Review of Resident indicated no docume treatment was comp 01/24/18. Review or assignment sheet in responsible for their Nurse #2 was assign #1's treatment on 01 During a telephone in PM, Nurse #2 stated pressure ulcer treatrinitial off on the TAR During a telephone in PM, the Wound Nurse Treatment Nurse she gave on 01/15/1 Calcium Alginate. During an Interview Director of Nursing (expectation that any and treatments be director of Nursing (expectation that any and treatments be director of Nursing (expectation that any and treatments be director of Nursing (expectation that any and treatments be director of Nursing (expectation that any and treatments be director of Nursing (expectation that the and implement any in 02/13/18 at 3:50 PM expectation that the and implement any in During an interview Administrator stated when an order is reciphysician, the Woun Physician Assistant,	#1's January 2018 TAR ented initials that his leted on his sacrum on if the daily schedule dicated the floor nurses were own treatments on 01/24/18. Interview on 02/15/18 at 2:40 If she provided Resident #1's ment on 01/24/18 but forgot to Interview on 02/13/18 at 3:10 Interview on 02/13/18 at 2:40 Interv	F 842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 02/15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		3271372313
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842	stated nothing shoul electronic medical rewritten order. She st should be document Resident #1's TAR. was her expectation orders and medical recomplete. 2. Resident #2 was a 01/01/18 with cumula Congestive Heart Fawith non-weight-bea Retention, Periphera and Dementia without Review of a nursing PM read the Nursing area to Resident #2' orders to cleanse the wound cleanser, approach foam dressing eneeded. The note renotebook was updated by Nurse #1. Review of a nursing AM as an addendum The note read on as noted with a stage 3 and left buttock. The treatment orders. Review of Resident Review of Rev	al record. The Administrator d be entered into the cord unless there was a ated all treatments provided ed and completed on The Administrator stated it that resident's physician records be accurate and admitted to the facility on ative diagnoses of allure (CHF) a fractured fibula ring status, Urinary al Vascular Disease (PVD) at behaviors. Inote dated 01/13/18 at 3:24 g Assistant reported open is right and left buttocks. New e right and left buttocks with only Calmoseptine ointment every other day and as ad the wound communication ed. This note was completed Inote dated 01/16/18 at 9:30 in for 01/14/18 was conducted. Sessment, Resident #2 was pressure ulcer to his right enote read currently pending #2's Wound Assessment 18 read a new stage 3	F8	42		
	pressure ulcer to his identified on 01/14/1	18 read a new stage 3 right and left buttock was 8. The report was completed rse and indicated the Medical				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	\ , ,	TE SURVEY MPLETED
		345534	B. WING _			C 2/15/2018
	ROVIDER OR SUPPLIER DHEALTH & REHABILITA	ATION CO		STREET ADDRESS, CITY, STATE, ZIP COD 2702 FARRELL ROAD SANFORD, NC 27330	· ·	2/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 842	to cleanse right butto apply Calmoseptine a dressing daily and as given to cleanse the wound cleanser, app wound bed and Calmand cover with a foar needed. Review of Resident # physician orders did orders for the resider 01/16/18. The electro on 01/16/18 at 12:02 entered the following auto-populated the Touttock with wound calmoseptine and a needed. The new ord left buttock (documer Wound Assessment In not added to the elected did not appear on the Review of Resident # indicated no docume treatment of Calmose was completed to his documented initials of Calmospetine, Silver to his left buttocks as Nurse on the Wound on 01/16/18. Review Report indicated the 01/16/18. Review of	on 01/16/18 with new orders ck with wound cleanser, and cover with a foam a needed. A new order was left buttock wound with ly Silver Alginate to the hoseptine to the peri-wound an dressing daily and as set years and an an area of the answer of the prosent of the peri-wound and dressing daily and as set years and period of the archived Time Card Treatment of the archived Time Card Treatment Nurse and the the archived Time Card Treatment of the archived Time Card Treatment Nurse archived the daily schedule dicated the Treatment Nurse archived the daily schedule dicated the Treatment Nurse worked the daily schedule dicated the Treatment Nurse licetated the Treatment Nurse worked the daily schedule dicated the Treatment Nurse	F8	42		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345534	B. WING		02/15/2018	
	ROVIDER OR SUPPLIER HEALTH & REHABIL	ITATION CO	27	TREET ADDRESS, CITY, STATE, ZIP CODE 102 FARRELL ROAD ANFORD, NC 27330	1 02/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 842	Continued From pa	ge 67	F 842			
	Treatment Nurse st	on 02/12/18 at 3:30 PM, the ated she completed his /18 but did not initial it on the				
	dated 01/26/18 rea sacrum right and le pat dry then apply \$ Calcium Alginate an	t #2's written physician orders d new orders to clean his ft buttocks with normal saline, Santyl (debriding ointment) and nd cover with a foam dressing d. This order was signed by				
	indicated no docum treatment of Santyl	t #2's January 2018 TAR nented initials that his and Calcium Alginate with a completed to his right and left d on 01/26/18.				
	indicated the floor r their own treatment	schedule assignment sheet nurses were responsible for s. Nurse #3 was assigned to #2's treatment on 01/26/18.				
	PM, Nurse #3 revea	interview on 02/15/18 at 2:40 aled she provided Resident treatment on 01/26/18 but n the TAR.				
	Director of Nursing expectation that an and treatments be medical record. The know where the Treorders she implement	on 02/15/18 at 12:00 PM, the (DON) stated it was her y new orders, assessments documented in the resident e DON stated she did not eatment Nurse was getting the ented for Resident #1.				
	_	on 02/13/18 at 11:10 AM, the ated there was a lack of				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345534	B. WING		C 02/15/2018		
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT	FATION CO	S 2 S	1 02/10/2010			
(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)	D BE COMPLETION		
F 842	instituted a wound of placed one at each of area was identified, nurses documented communication note checked the wound daily. The Treatmen not have any standing treatments and the pfor new orders where area was noted. During a telephone of PM, the Wound Nursessed Resident is stated it was her exporders were written accurate and complete PM, the PA confirmed present at the facility available after hours was aware Resident but was unsure of the someone calling her nurse orders but was stated it was her expendical record be as the Medical Director Telephone on 2/13/10 Director stated it was physician orders be initialing any new trestated treatments be documented in the results.	the floor staff to her so she communication notebook and nursing station. When a new she would know about it if the it in her wound book. She stated she communication notebooks to Nurse stated the facility diding orders for pressure ulcer physician should be contacted in a new area or worsening sinterview on 02/13/18 at 3:10 see Consultant stated she first #2's sacrum on 01/22/18. She prectation that treatment and the medical record was	F 842				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		345534	B. WING		C 02/15/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	02/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 842 F 865 SS=D	During an interview Administrator stated when an order is recomplysician, the Wound Physician Assistant, with the prescriber's the electronic medical rewritten order. She standed by the should be document Resident #2's TAR. was her expectation orders and medical complete. QAPI Prgm/Plan, Di. CFR(s): 483.75(a)(2)	ne part of the facility. on 2/14/18 at 9:50 AM, the it was her expectation that seived from the attending at Nurse Consultant or the the original order be written signature then entered into al record. The Administrator d be entered into the ecord unless there was a sated all treatments provided sed and completed on The Administrator stated it that resident's physician records be accurate and sclosure/Good Faith Attmpt (h)(i)	F 84	12	3/5/18
	Survey Agency no la promulgation of this §483.75(h) Disclosu A State or the Secredisclosure of the recexcept in so far as a sthe compliance of surequirements of this §483.75(i) Sanctions Good faith attempts	re of information. tary may not require ords of such committee uch disclosure is related to uch committee with the section. s. by the committee to identify leficiencies will not be used as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345534	B. WING		C 02/15/2018
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/13/2016
				2702 FARRELL ROAD	
SANFORD	HEALTH & REHABILITA	ATION CO		SANFORD, NC 27330	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION
F 865	Continued From page	e 70	F 86	5	
	This REQUIREMENT by:	is not met as evidenced			
	Based on staff and p	hysician interviews and		The facility failed to monitor assurance	e of
	record review, the fac	cility's Quality Assurance		notification to the physician per the Qu	ality
	Committee failed to m			Assurance process. Previous monitorii	ng
	•	tor the interventions the		for notification was completed per the	3
		e following the recertification		month schedule. When there were no	
		his was for one deficiency		issues or concerns identified, monitoring	ng
	recited during a comp	•		was discontinued. There have been 2	
		Rights at F 580 (F157). The		interim Administrators and a new Direct	tor
		e facility during two federal ws a pattern of the facility's		of Nursing since the last Quality Assurance for notification had been	
	inability to sustain and			completed. Monitoring for notification	to
	Assessment and Assu	_		the physician had not been completed	
	, lococomonic and , loco	aranee program:		since the end of January 2018.	
	The findings include:				
	Ū			The Administrator and Director of Nurs	ing
	This citation is cross r	referenced to:		received an in-service to include past	
				deficiency monitoring for physician	
	F580- Based on staff,			notification in the facility Quality	
	Assistant (PA), Wound			Assurance program by the Regional	
		review, the facility failed		Clinical Manager on 3/5/18 and to assi	
		f the resident's pressure		monitoring continues as part of the fac	ility
		admission and failed to		QA program until certainty of the	
		rs, resulting in the resident's		monitoring has been effective and no	,
		m 1/9/18 till 1/12/18. The e physician approval before		longer necessary. 100% of all licensed nurses received an education on	,
		ure ulcer treatment. The		physician notification on 2/15/18 by the	
		the physician of the Wound		Staff Development Coordinator. All ne	
		atment orders for Resident		licensed staff, Administrator, and Direct	
		The facility failed to notify		of Nursing will receive the education	
	•	orsening of the pressure		during orientation.	
		der for treatment. Resident			
	#1's sacral pressure u	ulcer was described as		Utilizing a Change in Skin Condition A	
	"quarter size" suspect			Tool, the Unit Managers x 2 will review	
		ea of discolored intact skin)		100% of nurse progress notes and 100	
		escribed on 01/22/18 as an		of the Treatment Administration Record	
		essure ulcer measuring		daily to identify new wounds/skin chan	
	13.5-centimeter (cm)	length, 12.5 cm width and		to assure the physician has been notifi	ed.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED					
		345534	B. WING			l	C 1 5/2018
	ROVIDER OR SUPPLIER HEALTH & REHABILITA			27	TREET ADDRESS, CITY, STATE, ZIP CODE 702 FARRELL ROAD ANFORD, NC 27330	<u> 021</u>	13/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 865	1.5 cm depth having of appearing yellow/black deteriorated. Reside an infected stage 4 pth debridement and antial linterview on 2/15/18 and Administrator acknown reciting of F580 durin 02/15/18. The Administrator acknown reciting of F580 durin 02/15/18. The Administration between the communication betwe	excessive necrotic tissue exk in color and as ent #1 was hospitalized with ressure ulcer requiring sharp biotic therapy. at 9:50 AM, the eledged understanding of the greater stated she felt the related to the lack of ean Physician #1, the the Wound Nurse enistrator stated it became anuary 2018 during the stated the Unit Managers attention interim ated she also recently the Treatment Nurse was not und-up meetings where were discussed daily. She extation that the Treatment ended those meetings and the for admission treatment ent #1's pressures as	F8	365	Monitoring will occur Monday through Friday x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 4 months. The Director of Nursing will review and initial the Audit Tool weekly x 8 weeks, then monthly x months for trends and concerns. The Director of Nursing will present the results of the monitoring to the Quality Assurance Committee monthly x 6 months for trends, the need to modify a part of the process, and the need to continue monitoring. The Administrator will be responsible for implementing the plan of correction.	4 any	