PRINTED: 08/08/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIF IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345155	B. WING		0:	C 7/ 06/2018
	ROVIDER OR SUPPLIER PH HEALTH AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203	,	
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F 00	00		
	from 7/2/18 through	ow up survey was conducted 7/3/18 and 7/5/18 through leopardy was identified at:				
	CFR 483.25 at tag F	F600 at a scope and severity J F684 at a scope and severity J F925 at a scope and severity J				
	The tags F600 and I Quality of Care.	F684 constituted Substandard				
		began on 6/14/18 and was A partial extended survey				
		the previous survey of 6/7/18 ctive 7/6/18 except F656 uring this survey.				
F 600 SS=J	Free from Abuse and CFR(s): 483.12(a)(1	<u> </u>	F 60	00		7/21/18
	Exploitation The resident has the neglect, misappropriand exploitation as concludes but is not lincorporal punishment	om Abuse, Neglect, and e right to be free from abuse, iation of resident property, defined in this subpart. This mited to freedom from t, involuntary seclusion and mical restraint not required to nedical symptoms.				
	§483.12(a) The facil					
	physical abuse, corp involuntary seclusion					
ABORATORY	 DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE

Electronically Signed

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

07/27/2018

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345155	B. WING		C 07/06/2018	
NAME OF PI	ROVIDER OR SUPPLIER	1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 000.2010	
				230 EAST PRESNELL STREET		
RANDOLF	PH HEALTH AND REHA	BILITATION CENTER		ASHEBORO, NC 27203		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		
F 600	Continued From pag	ge 1	F 60	0		
	_	view, Nurse Practitioner (NP)		Preparation and/or execution of this	Plan	
		and resident interviews, the		of Correction does not constitute		
		implement interventions in		admission by the provider of the truth	of	
	, ,	e resident's refusal of daily		facts alleged or the conclusions set for		
	•	e ordered by the physician to		in the statement of deficiencies. This		
	treat 1 of 2 residents	s for having maggots on her		of correction is prepared solely becau		
	body. Resident #2	experienced a second		is required by the provision of the Fed	deral	
		ots growing on her body		& State Law.		
	which required conti	inued treatment at the facility.		F600		
	Immediate jeopardy	began on 6/22/18 when				
	Resident #2 refused	I showers and the facility		1.The plan of correcting the specific		
	failed to implement	any interventions to address		deficiency. The plan should address t	he	
		al of showers. Maggots were		process that lead to the deficiency.		
		bdominal folds. Immediate				
		ved on 7/06/18 when the		a)On July 5, 2018 Resident #2 had a		
		a credible allegation of		shower and was made aware by the	u	
		removal. The facility will		Nurse Practitioner the importance of		
		iance at a lower scope and no actual harm with a potential		need for a shower versus a bed bath. On July 4, 2018 the Unit Coordinators		
		at is not Immediate Jeopardy)		Unit Managers, Wound Care Nurse,	,	
		g of systems are put in place		Treatment Nurse, and Assistant Direct	etor	
	and to complete em			of Nursing completed head to toe skii		
	•			assessments on 100% of the residen		
	Findings included:			No negative findings of flies or magge	ots	
				were identified as a result of this audi	t. On	
		mitted on to the facility on		July 5, 2018 the Director of Nursing,		
	_	were diabetes, at risk for		Assistant Director of Nursing, Unit		
	falls, bowel incontine	ence, and hemiplegia.		Managers, and Unit Coordinators		
	Desident #01	alam data d 4/07/40		conducted a %100 audit of all resider		
	-	plan dated 4/27/18 revealed		identify refusals of bed baths and sho		
	, •	ons for dependent on staff for Illiant like it is a like		as ordered by the facility's physician. 6, 2018, all residents identified had the	_	
		home, fluid volume deficit,		care plans updated by the Resident 0		
		iabetes, at risk for falls, bowel		Management Director and MDS	Juic	
		legia, potential for pressure		Coordinators to include resident spec	ific	
	·	pairment to skin integrity.		interventions to attempt when refusal		
				showers or bed baths occur. All licens		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
						С	
		345155	B. WING _		<u> </u>	07/06/2018	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CI	TY, STATE, ZIP CODE		
				230 EAST PRESNELL	LSTREET		
RANDOLF	'H HEALIH AND RE	HABILITATION CENTER		ASHEBORO, NC 2	?7203		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 600	Continued From	ongo 2	Г.	00			
1 000	Continued From p	-	F 6				
		imum Data Set dated 5/24/18			ertified nursing assistants to		
		lent had adequate hearing, clear			ne, part-time, and as neede	ea	
		understood and understands. an intact cognition. The			ere in-serviced by Staff Coordinator (SDC)July 6,		
		extensive assistance of 2			cation of refusal of bed		
		nsfers, bed mobility, and			ers. No licensed nurses or		
		sing and personal care required			ng assistants to include all		
		imited assistance.			time, and PRN will be		
					rk until the in-service has		
	A Nurses' note da	ted 6/19/18 at 3:31 pm revealed		been complete	ed. On July 5, 2018 the		
		naggots in the abdominal folds.			rsing, Assistant Director of		
		ioner was notified and an order			Development Coordinator,	,	
		an anti-bacterial wash every			rvisor, Unit manager, and		
	day.				tors educated all staff		
	D				ime, part-time, and PRN or	n	
		nt #2's physician orders an order dated 6/19/18, which			buse and Neglect Policies es emphasizing that not		
		e Nurse Practitioner for an			nysician orders was		
	anti-bacterial was				glect. No staff will be		
	anti sactoriai wac	novery day.			rk until they have been		
	Further review of	the physician orders revealed			is alleged that the facility		
		order on 6/20/18 for Resident #2			ment any interventions in		
	to receive a show	er each day.		place to addre (Resident #2)	ess refusal of daily showers	S.	
	Review of a nurse	es' note dated 6/22/18 revealed					
	the resident felt a	shower every day was too			ure for implementing the		
	much.				an of correction for the		
				specific deficie	ency cited.		
		dated 6/25/18 revealed Nystatin		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	204041 5: 4 (1)		
	*	inal folds and groin every shift		1 '	2018 the Director of Nursin	g,	
	(tor candida) was	ordered for Resident #2.			ctor of Nursing, Staff Coordinator, Nursing		
	Review of a nure	es' note dated 6/30/18 revealed			nit manager, Unit		
		efused some of her every day			educated all staff including		
		requested to go back to the			time, and PRN on the		
	twice a week sch	· ·			e and Neglect Policies and		
					mphasizing that not		
	On 7/3/18 at 9:45	am an interview was conducted			nysician orders was		
	with the Treatmer	nt Nurse (TN) who stated that			glect. No staff will be		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345155	B. WING			C 7/06/2049	
NAME OF DE	ROVIDER OR SUPPLIER	0-10100		STREET ADDRESS, CITY, STATE, ZIP COD		7/06/2018	
NAIVIE OF FE	NOVIDER OR SUFFLIER				L		
RANDOLP	H HEALTH AND REHA	BILITATION CENTER		230 EAST PRESNELL STREET			
				ASHEBORO, NC 27203			
(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)	I SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From pag	e 3	F 60	00			
	Resident #2 had may bed. The TN stated #2 had several magg debris and two in the abdomen about 6/20 (NP) was notified and anti-bacterial wash with the resident refused assistants provided a wash. Nursing staff refusal. On day 5 the maggots again in the fold. The TN stated to information was passistanting. The staff was change. The staff was several maggots and the staff was change.	ggots on her body and in her she observed that Resident gots in her bed with food skin folds of her lower 1/18. The Nurse Practitioner d daily showers with vere ordered. By about day 3 her showers and the nursing a bed bath with anti-bacterial was not notified of the eresident had a few a same area of her abdominal that the maggot issue sed verbally during shift as verbally directed to look		allowed to work until they hav in-serviced. All licensed nurse certified nursing assistants to full-time, part-time, and PRN vin-serviced on July 6, 2018 or of refusal of bed baths or show licensed nurses or certified nurses assistants will be allowed to win-service has been completed hired staff we be in-serviced of facility's Abuse and Neglect P during their classroom oriental providing care to residents. Linurses will document resident showers and interventions attriprogress note.	es and include were n notification wers. No ursing vork until the d. Newly on the olicies ution prior to censed ts refusals of		
	for maggots during routine care. On 7/3/18 at 11:45 am an interview was conducted with the Assistant Director of Nursing (ADON) who stated that Resident #2 had maggots found on her body shortly after another resident was found to have maggots. The resident was found to have maggots in the folds of her lower abdominal skin. The ADON stated the TN identified the maggots during treatment and was not sure if there was tissue injury. The resident was always dressed and it was unclear how maggots were able to get under her clothing. The NP was called and an order for anti-bacterial wash and shower each day was obtained. The maggots were found on Sunday and the Administrator was verbally informed on Monday of the second incidence of maggots. The ADON expected the treatment nurse assigned for that day to inform her if there were any maggots. The ADON stated that the maggots were mentioned in the Monday morning meeting but not discussed for prevention or new process. The staff were			3. The monitoring procedure to the plan of correction is effect specific deficiencies cited rem corrected and/or in compliance regulatory requirements. a) Daily Monday - Friday in the Morning Meeting for 12 weeks Director of Nursing, Assistant Nursing, Staff Development C Unit Coordinators, Unit Managaudit Treatment Administration residents who refuse showers baths to validate showers and are offered as needed based preference, and offered specinterventions to encourage the comply if there is a physician's Licensed Nurse is identified a offered various specific interventions to encourage the comply if the specinterventions to encourage the comply if there is a physician's Licensed Nurse is identified a offered various specific interventions to encourage the comply if the specific interventions to encourage the comply if there is a physician's Licensed Nurse is identified a offered various specific interventions to encourage the comply if there is a physician's Licensed Nurse is identified a offered various specific interventions to encourage the comply if there is a physician's Licensed Nurse is identified a offered various specific interventions to encourage the comply if there is a physician's Licensed Nurse is identified and offered various specific interventions to encourage the comply in the specific interventions to	ive and that nains be with the e Clinical s, the Director of coordinator, gers will an Records of s and bed bed baths on resident fic e resident to s order. If a s not having entions		

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	IP CODE	1 07700/2010
				230 EAST PRESNELL STREET		
RANDOLF	PH HEALTH AND REHAB	ILITATION CENTER		ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE FO THE APPROPRIA	DATE
F 600	Continued From page	÷ 4	F 6	500		
	with Resident #2 who increase in the numb 1 to 2 weeks ago. The week ago there were and in her bed which ordered anti-bacterial day which were still in resident stated that do the showers there we had hatched. The resident informed the shower. The resident informed the shower. The resident the NP her lymph edic cause maggots and a cause maggots and cause maggots and cause maggots and a cause maggots and cause	ne maggots returned. The staff that she did not need a t stated she was informed by ema can attract flies and agreed to have a shower. an interview was conducted very familiar with Resident alert and oriented and able sisons. The resident was her intative. The resident was nal care and preferred a telephone and preferred a telephone and maggots in the she ordered daily showers beacterial wash. The ily showers and education owers were needed. After		b)The DON and/or the A findings of audits month! Assurance Performance (QAPI) Committee mont for tracking and trending follow up action determine team. 4.Title of person responsimplementing the accept a)The DON and/or the A responsible for the imple acceptable plan of corresponsible for the imple acceptable. The corrective completed. The corrective must be acceptable to the a) July 21, 2018	ly to the Quality improvement the Improvement the Improvement of I	ths all Pl

	(X3) DATE SURVEY COMPLETED C		
D 1999	ے 06/2018		
NAME OF PROVIDER OR SUPPLIER RANDOLPH HEALTH AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203	,		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
Continued From page 5 and by day five the resident had maggots again in her abdominal folds, same place. The showers were more effective at washing the lymph edema and any potential fly eggs. The resident did not like to transfer via the mechanical lift because of her size and fear of falling which contributed to the shower refusal. The resident thad lymph edema which wept fluid continuously and put the resident at increased risk for maggots. The NP stated that when a resident refused care or treatment her expectation was for staff to re-educate the resident to obtain compliance and if the refusal continued to inform her. The NP has attempted to get resident cooperation to make better choices by explaining why and the consequences. This method had been repeated and sometimes it worked and sometimes it had not. On 7/5/18 at 10:45 am an interview was conducted with Resident #2 who stated that the resident had a shower this morning and was made aware by the NP the importance of the need for a shower versus her preferred bed bath. The staff used the shower gurney to transfer the resident to the shower and that worked better than the mechanical lift. The resident stated that it was over a five-day period that she had maggots and was very concerned about their returning. The resident had received her usual, daily ant-anxiety medication. The resident commented that the flies were better. On 7/5/18 at 12:15 pm an interview was conducted with Nursing Assistant (NA) #1 who stated that she was assigned to Resident #2 who received a shower or complete bed bath very			

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	ROVIDER OR SUPPLIER TH HEALTH AND REHA			STREET ADDRESS, CITY, STATE, ZIP COD 230 EAST PRESNELL STREET ASHEBORO, NC 27203		7770672016	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 600	ordered. NA #1 was had seen flies in the more than usual. We resident to take a shand said she did no #1 provided a bed be shower order continus he would inform the a shower. On 7/5/18 at 11:00 a conducted with the lew who stated that Resident to take her ordered shower called the resident's the resident to take effective. The resident family member was ordered daily shower a shower and the nuresident a bed bath called as an interver receive a shower fo shower and maggot	ge 6 e her shower when it was a saware of the maggots and e resident's room, but not //hen the NP ordered for the hower, the resident refused to need a shower anymore. NA eath and later learned that the ued. NA #1 indicated that e nurse if the resident refused arm an interview was Director of Nursing (DON) sident #2 sometimes refused and the staff at times had a family member to influence a shower, which was ent was in agreement that her called. On day three of the ear the resident refused to have ursing assistant gave the a The family member was not intion. The resident did not a two days of the ordered daily sappeared again. The DON's nursing assistants to inform	F 60	·			
	the nursing assistant of the refused show and maggots were a resident on 6/23/18. The Administrator, A Corporate Nurse Conversing were notified on 7/5/18 at 12:32 p. On 7/6/18 the facility	Assistant Administrator, onsultant and Director of do the Immediate Jeopardy					

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		345155	B. WING			C 7/06/2018	
	ROVIDER OR SUPPLIER PH HEALTH AND REHAL			STREET ADDRESS, CITY, STATE, ZIP COD 230 EAST PRESNELL STREET ASHEBORO, NC 27203			
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F 600	Continued From pag		F 60	00			
		g the specific deficiency ses that lead to the deficiency					
	with diagnosis included obesity, Chronic Obsanxiety, Hemiplegia 6/15/18 a Weekly Skeperformed with no fir Resident #2 was not abdominal folds. Rewas notified with ordereceived. On 6/20/1 Practitioner ordered refused showers on 6/27/18 and 6/29/18 record for Resident #2 refusals of care related failed to implement sencourage the reside physician's order to skin evaluation assecharge Nurse assignated where were no signs the Unit Coordinator regarding her bed be received good bed be concerns with bed be "A Root Cause Anal Interdisciplinary Tear Home Administrator,"	adings noted. On 6/19/18 ed to have maggots to her sident #2 Nurse Practitioner ers for anti-bacterial wash 8 Resident #2 Nurse Daily Showers. Resident #2 6/22/18, 6/25/18, 6/26/18, After review of the medical #2 noting the number of ed to showers, the center pecific interventions to ent to comply with the shower. Resident #2 had a assment performed by the ned to Resident#2 on 7/6/18; of maggots noted. On 7/6/18 interviewed Resident #2 aths. Resident #2 stated she aths and denied having any aths. ysis was conducted by the m (IDT) including the Nursing					
	Coordinator, Unit Co and Social Services	ordinators, Unit Managers Director on 7/5/18 and it was e was not a resident specific					

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	· /	ATE SURVEY OMPLETED	
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	ROVIDER OR SUPPLIER PH HEALTH AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203	•	
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F 600	resident to help pro resident will comply orders. The IDT de educate the resider showers including raudit of the current 7-5-18 and did not a physician orders for refusals. An additi the IDT was the Ce lacked knowledge of the plan of correction for "Residents who refusals who are not offered encourage the residentified as having All residents in the assessment completed coordinators, Unit I Nurse, Treatment Nursing. No other rehaving maggots. On 7/5/18 identified updated to include	ge 8 rnate interventions to offer the mote the likelihood the with showers per physician attermined the center did not not on the risks of refusals of isk of maggots. The facility residents was reviewed on reveal any other residents with reshowers or documented onal Root Cause identified by riffed Nursing Assistants of how to identify maggots. Implementing the acceptable or the specific deficiency cited: Tuse bed baths and showers specific interventions to dent to comply have been the potential to be affected. In the potential to be affected as the potential to be affected as the potential to dent to comply have been and Assistant Director of the potential to be affected as the potential to the potential to be affected as	Fé	500		
	Nursing, Staff Deve Supervisor, Unit Ma Coordinators re-edu	ursing, Assistant Director of elopment Coordinator, 11-7 anagers, and Unit ucated licensed nurses and assistants on Abuse and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 600	Beginning 7/6/18 N Certified Nursing As work until the training also included ensure failure to provide shordered by the physical	beginning on 7/5/18. Licensed Nurses and no ssistants will be allowed to ag is complete. This education ing staff awareness that howers or bed baths as sician can constitute resident and the side of the side o	F 6	00	
	interventions offere accepted or refused Administration Reco Progress Notes. To no tolerance approa policy. Newly hired educated on Abuse the Staff Developm Nursing, Assistant I Managers and / or	d and if the interventions were			
	Nurses have received six of the Licensed received the educal basis. Three of the to receive the educal One of the License receive the education Act (FMLA). Each of the have not yet receive permitted to work under the educal Certified Nursing Astreceived the educal basis, 7 of the Certified Six of the C	Nurses, 30 of the Licensed ed the education for F600. Nurses who have not yet tion work on an as needed Licensed Nurses who has yet ation are currently on vacation. It is on the Licensed Nurses who has yet to the Licensed Nurses who ed the education will not be not the education is received. The desired Nurses who ed the education is received. The desired Nurses who ed Nursing Assistants have tion for F600. 21 of the essistants who have not yet tion work on an as needed fied Nursing Assistants who the education are currently on			

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F 600	on Family Medical L Certified Nursing As received the educat work until the educat The monitoring proc of correction is effect deficiency cited rem compliance with the "Daily Monday - Fric Meeting for 12 week Assistant Director of Coordinator, Unit Co will audit Treatment residents who refusivalidate showers an needed based on re offered specific inter resident to comply v Licensed Nurse is ic various specific inter noted, the nurse will re-education. " The Director of results of the audits and Performance In monthly for six moni including new interv is sustained ongoing	ne Certified Nursing yet to receive the education is eave Act (FMLA). Each of the sistants who have not yet ion will not be permitted to tion is received. edure to ensure that the plan stive and that specific ains corrected and / or in regulatory requirements. lay in the Clinical Morning is, the Director of Nursing, Invising, Staff Development cordinators, Unit Managers Administration Records of the showers and bed baths to d bed baths are offered as sident preference, and ventions to encourage the with the physician's order. If a lentified as not having offered reventions when refusals are the provided a one to one Nursing will present the to the Quality Assessment approvement Committee this for recommendations tentions to assure compliance g.	F6	, , , , , , , , , , , , , , , , , , ,		
	Nursing, Staff Devel Coordinators, Unit N Supervisor and 11-7 education for the Nu resident refuses a b	Nursing, Assistant Director of opment Coordinator, Unit Managers, 3-11 Nurse Nurse Supervisor began ursing Assistants that if ed bath or shower that the e informed of the refusal.				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345155	B. WING _			C 07/06/2018
	ROVIDER OR SUPPLIER PH HEALTH AND REHAE	I		STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203	<u> </u>	07/00/2010
(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 CORREC ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APPLICATION CONTROL OF	OULD BE	(X5) COMPLETION DATE
F 600	The Nursing Assistant education on what may 7/6/18 no Nursing Asswork until the training. The Title of the person implementing the acconversing Home Admin for implementing this correction. Immediate Jeopardy Validation: Immediate Jeopardy at 4:15 pm validation credible allegation for	ats were also provided aggots look like. Beginning sistant will be allowed to a is complete. In responsible for septable plan of correction: sistrator will be responsible acceptable plan of	F6	500		
F 656 SS=D	assistant for each of evidence of in-service and maintaining a cle completed for 123 sta 56 staff members on outside professional preat the facility grour 7/6/18 the Administra and grounds were tree Develop/Implement CCFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The facility grounds were tree grounds were tree for each resident rights set for §483.10(c)(3), that in objectives and timefra	the 7 facility halls for a completion. Pest control can facility in-service was aff members on 7/2/18 and 7/3/18. On 7/6/18 an pest control was observed to not with a liquid spray. On tor stated that the facility cated for flies. Comprehensive Care Plan censive Care Plan control was observed to not with a liquid spray. On the stated that the facility cated for flies. Comprehensive Care Plan comprehensive Care Plan consistent with the that §483.10(c)(2) and	Fé	556		7/21/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345155	B. WING _		C 07/06/2018
	ROVIDER OR SUPPLIER PH HEALTH AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203	1 01700/2010
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 656	assessment. The codescribe the followin (i) The services that or maintain the reside physical, mental, an required under §483 (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclutreatment under §48 (iii) Any specialized rehabilitative service provide as a result of recommendations. If findings of the PASA rationale in the resident's represent (A) The resident's godesired outcomes. (B) The resident's p future discharge. Fawhether the resident community was assolocal contact agencial entities, for this purposition, as appropriate and resident as appropriate as a proportion of the policy of the purposition of the policy of the purposition of t	tified in the comprehensive omprehensive care plan must ong - care to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and to would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights auding the right to refuse 33.10(c)(6). Services or specialized es the nursing facility will of PASARR of a facility disagrees with the ARR, it must indicate its dent's medical record. With the resident and the active(s)-oals for admission and reference and potential for acilities must document t's desire to return to the essed and any referrals to less and/or other appropriate	F6	56	
	section. This REQUIREMEN by: Based on record re interview, and staff facility failed to deve centered care plans	IT is not met as evidenced eview, Nurse Practitioner (NP) and resident interviews, the elop comprehensive person to address leaves of om the facility and refusals of		Preparation and/or execution of this of Correction does not constitute admission by the provider of the trufacts alleged or the conclusions set in the statement of deficiencies. This	th of forth

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345155	B. WING _				C 06/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				23	30 EAST PRESNELL STREET			
RANDOLF	PH HEALTH AND REHAI	BILITATION CENTER		Α	SHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From pag	e 13	F 6	356				
					of correction is prepared solely becaus is required by the provision of the Fede & State Law.			
	Findings included:			F656				
	recently readmitted of discharged to the horemained in the hosp. A nurses' note dated #1 was started on arright leg wound infect (leave of absence) to chair going to town. resident returned to leg/foot dressing mist. Review of a nurses' the resident continue treatments and refuschanged. A review of the out or responsibility form reof building was on 6/facility almost every resident #1's care per 6/14/18 revealed goal care decisions at time independent with sm self-care deficit, resis schizophrenia, multiper services in the hosp.	Resident #1 was admitted on 8/10/17 and ently readmitted on 6/24/18. The resident was charged to the hospital on 6/30/18, and nained in the hospital during this survey. urses' note dated 6/12/18 revealed Resident was started on an antibiotic for treatment of a att leg wound infection. Resident went LOA ave of absence) twice in his motorized wheel air going to town. Both LOAs on 6/12/18 the ident returned to the facility with his right lower (foot dressing missing. View of a nurses' note dated 6/13/18 revealed resident continued to be non-compliant with atments and refusal to have wound dressings anged. Eview of the out of facility release of ponsibility form revealed Resident #1's last out building was on 6/13/18. The resident left the lity almost every day for the past 3 months. Esident #1's care plan dated review date 4/18 revealed goals and interventions for daily be decisions at times refused wound treatment, espendent with smoking, activities of daily living force deficit, resistive to care related to			1.The plan of correcting the specific deficiency. The plan should address th process that lead to the deficiency. a)The care plan for Resident #1 was updated by the Resident Care Management Director (RCMD) on July 2018 after Resident #1 returned from hospital. Resident #1 scare plan addresses his independent leave of absences (LOA) from the facility and refusals of care and treatments as well re-enforcing the dressings, as needed, when Resident #1 goes on independer LOA. Resident #2 scare plan was updated July 6, 2018 by the Resident Care Management Director to include refusals of care and treatments. Re-education was provided by the Dist Director of Care Management on July 6 2018 to Resident Care Management Director of Nursion policies and procedures for develop comprehensive care plans for residents who take independent LOA from the facility and residents who have refusal care and treatments. It is alleged that the facility failed to develop comprehensive person centered care plans to address	9, as at rict 5, ing ing s of he		
	lower extremity.	and cellulitis of the right			independent LOA from the facility (Resident #1) and refusals of care and treatments (Resident #1 and #2).			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345155	B. WING			C 07/06/2018
NAME OF P	ROVIDER OR SUPPLIER	1.5.55		STREET ADDRESS, CITY, STATE,	ZIP CODE	07700/2010
TO UNE OF TH	TO VIDER OR GOTT EIER			230 EAST PRESNELL STREET		
RANDOLF	H HEALTH AND REHAE	BILITATION CENTER				
				ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVI CROSS-REFERENCEI	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 656 Continued From page 14		e 14	F 6	56		
	resident's need to ha	ve his wound dressing more				
	secured when on LOA from the facility. There			2.The procedure for im	plementing the	
	were limited care plan			acceptable plan of con	· -	
	-	ent's personal and wound		specific deficiency cite		
		als. Interventions for wound			~.	
	care were to encourage compliance with treatments and to administer treatments as ordered and observe for effectiveness. There was no intervention for of wound care needs related to LOA.			a)It is the policy of Rar	ndolph Health and	
				Rehabilitation to ensur		
				residents have compre		
				for residents who take		
				from the facility and re-		
				refusals of care and tre		
	Resident #1's quarter	rly Minimum Data Set dated		education was provide	d by the District	
	6/14/18 revealed the	resident had adequate		Director of Case Mana	igement on July 6,	
	hearing, clear speech	n, and understood and		2018 to Resident Care	Management	
	understands. He had	d intact cognition, no		Director (RCMD)and A	ssistant Director of	
	psychosis, and no be	haviors. The resident		Nursing(ADON)on poli	cy and procedure	
	required one-person	extensive assistance for bed		regarding comprehens		
	mobility and total dep	endence of two for transfer.		residents who take ind		
		off the unit was supervision		the facility and residen	ts who have	
		g, personal hygiene, and		refusals of care and tre		
		son physical assistance and		audit completed on all		
		. The resident's diagnoses		independently take LO		
		ression, manic depression,		Director of Nursing (DC	•	
		ndence on a wheel chair, PU		Director of Nursing (AI		
		4, polyneuropathy, and		2018. 100% audit com		
	Burkitt lymphoma (ca	incer of the lymphatics).		residents who have ref		
	(treatments by DON an	•	
		unication) dated 6/14/18		2018. Results of audit	•	
		informed that the resident		all residents who take and refuse care and tre		
	had been noncomplia	ant with treatments.				
	Nurses' note dated 6	/24/18 revealed Resident #1		comprehensive care pl July 6, 2018. No additi		
	refused his weight in			noted without independ		
	reiuseu ilis weigill III	order to go sinoke.		refusal and treatment		
	Nurses' note dated 6	/26/18 revealed hematuria		care plans. DON and/o	•	
		sed to go to the hospital as		maintain a communica		
		was made aware. Resident		updates to the 24 hour		
	#1 stated "I just got b			discussed daily in clinic		
	3.4.54 1 1451 901 5			revisions to care plans		
			1			I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345155	B. WING				C 06/2018
NAME OF PE	ROVIDER OR SUPPLIER	0.0.00		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 077	06/2016
TO UNIC OT TH	TO VIDER OR OUT FEEL						
RANDOLP	H HEALTH AND REHAE	BILITATION CENTER			0 EAST PRESNELL STREET		
				AS	SHEBORO, NC 27203		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	e 15	F 6	556			
	On 7/3/18 at 9:45 am	an interview was conducted					
		urse (TN) who stated that					
		uently known to leave the			3. The monitoring procedure to ensure	that	
		nself out and by motorized			the plan of correction is effective and the		
		treme heat as far as 2 miles			specific deficiencies cited remains	iat	
		vere times when the resident			corrected and/or in compliance with the	<u>ح</u>	
		while outside and his			regulatory requirements.		
		d there were times when the			garatery requirements		
		ave his dressing changed			a)The ADON and/or the RCMD will aud	dit	
	putting him at higher risk for infection. On 7/5/18 at 10:30 am an interview was				residents who take independent LOA a		
					residents who have refusals of care an		
					treatment for four weeks, then five		
	conducted with the fa	cility Nurse Practitioner (NP)			random care plans weekly for eight we	eks	
	who stated she was v	very familiar with Resident			to ensure that the facility care plans are	Э	
	#1. The resident was	s frequently non-compliant			developed according to facility policy a	nd	
	with wound care dres	ssing change. The resident			that they contain required components		
	preferred to have his	dressings changes while still			needed to care for each resident.		
	in bed before he got	up to his motorized wheel					
	chair. The NP stated	the resident was alert and			b)The ADON and/or RCMD will report		
		on 6/13/18 she evaluated the			findings of audits monthly to the Quality	-	
		I the dressing was soaked			Assurance Performance Improvement		
		nage was like mud. The			(QAPI) Committee monthly for three		
	resident refused to go				months for tracking and trending		
	Department (ED) so				purposes with all follow up action		
	-	piotic for concerned infection			determined by the QAPI team.		
		and care was completed after					
		resident had an intact			4 Title of a consumer on title for		
		schizophrenia. The NP			4. Title of person responsible for		
		nt made poor choices. The			implementing the acceptable POC.		
	NP stated that at time	-			a)The ADON and/or the BCMD will be		
	refused as well as wo	Juliu Cale.			 a)The ADON and/or the RCMD will be responsible for the implementation of t 	he	
	On 7/5/18 at 11:00 as	n an interview was			acceptable plan of correction.	IC	
	On 7/5/18 at 11:00 am an interview was conducted with the Director of Nursing (DON)				acceptable plan of correction.		
		dent #1 had a long history of					
		personal care. The resident			5.Dates when corrective action will be		
		his motorized wheel chair			completed. The corrective action dates		
		e dressings to be changed			must be acceptable to the State.		
		WC. The DON agreed that			mast be deceptable to the state.		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345155	B. WING _				06/2018	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 011	00/2010	
				23	0 EAST PRESNELL STREET			
RANDOLF	PH HEALTH AND REHAB	ILITATION CENTER		AS	SHEBORO, NC 27203			
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page	e 16	F 6	556				
	always effective for th	interventions were not his resident and that his very he facility should be care			a)July 21, 2018			
		dmitted on to the facility on were diabetes, at risk for nce, and hemiplegia.						
	goals and intervention emotional and social desired to return to he poor oral hygiene, dia incontinence, hemiple ulcer, and actual impa There were no interve an order to shower ex	an dated 4/27/18 revealed his for dependent on staff for needs, self-care deficit, ome, fluid volume deficit, abetes, at risk for falls, bowel egia, potential for pressure airment to skin integrity. The entions on the care plan for very day anti-bacterial wash to address refusals of care veffective.						
	revealed the resident speech, and was und The resident had an i resident required exterpersons for all transfer locomotion. Dressing 2 staff members limited required set up. The neurogenic bladder, or A Nurse Practitioner's revealed for the residuanti-bacterial wash. A nurses' note dated	ensive assistance of 2 ers, bed mobility, and g and personal care required ed assistance. Meals active diagnoses were diabetes, and hemiplegia. s order dated 6/20/19 ent to shower every day						
	resident felt a shower and had declined her	every day was too much shower.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345155	B. WING		07/06/2018	
	ROVIDER OR SUPPLIER PH HEALTH AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203	1 01/100/2010	
(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 SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 656	Continued From pa	nge 17	F 65	6		
	refused some of he	0/18 revealed the resident had er every day showers and had ck to the twice a week				
	with the Treatment resident refused he nursing assistants staff was not notified in a bed bath provide	nm an interview was conducted Nurse (TN) who stated the er ordered showers and the provided a bed bath. Nursing ed of the refusal which resulted ded that was not effective to occurrence of maggots being ody.				
	with Resident #2 w there were maggot bed. The NP order showers every day time. The resident bed bath and when	om an interview was conducted ho stated about a week ago is on her stomach and in her ed anti-bacterial wash and which were still in place at this stated that she preferred a is she refused a shower and it bath instead, the maggots				
	with the NP who was Resident #2. The rand able to make he resident was her on the resident was keep and preferred a been maggots to her right and maggots in the ordered daily show anti-bacterial wash showers and educations which was not been showers were need to make the profession with the profession was not been was not been with the profession was not been was	am an interview was conducted as also very familiar with resident was alert and oriented are own decisions. The way resident representative. In a side of the lateral lower abdominal fold as bed. The NP stated she are and cleanse with the resident agreed to daily attorn was provided why ded. After the first three days it to complain to nursing that a				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		345155	B. WING _			C 07/06/2018
	ROVIDER OR SUPPLIER PH HEALTH AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203		37700/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	inform personal car the resident that sh shower. The NP st manipulated staff. of the resident's ref for daily showers ar maggots again in hiplace. The shower washing the lymph eggs. The resident mechanical lift becafalling. The resident wept fluid continuou increased risk for m. The NP stated that or treatment her ex re-educate the residif the refusal continuous increased of the resident was assign received a shower day. The resident problem to be coaxed to tak aware of the maggoresident's room, but the NP ordered for the resident refused shower anymore ar NA #1 was aware of	on much for her and began to be staff that the NP informed en olonger needed a daily atted that the resident. The staff did not inform the NP usal on day three of the order and by day five the resident had be abdominal folds, same swere more effective at edema and any potential fly did not like to transfer via the ause of her size and fear of at had lymph edema which usly and put the resident at laggots. When a resident refused care pectation was for staff to dent to obtain compliance and	F6	56		
	conducted with the who stated that Res	am an interview was Director of Nursing (DON) sident #2 sometimes refused and the staff at times had				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345155	B. WING _				C 06/2018
	ROVIDER OR SUPPLIER PH HEALTH AND REHAB	ILITATION CENTER		23	REET ADDRESS, CITY, STATE, ZIP CODE 80 EAST PRESNELL STREET SHEBORO, NC 27203		00,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			(X5) COMPLETION DATE	
F 656 F 684 SS=J	the resident to take a effective. On day three shower the resident reand the staff gave the family member was not the resident did not redays of the ordered direappeared. The DC care plan did not concontact the resident's resident refused a shower of the care appeared.	amily member to influence shower, which was ee of the ordered daily efused to have a shower e resident a bed bath. The ot called as an intervention. Execute a shower for two aily shower and maggots DN confirmed the resident's tain an intervention to family member when the ower. The DON would hat were being implemented		656			7/21/18
	applies to all treatment facility residents. Base assessment of a resident residents received accordance with professor practice, the comprehestare plan, and the resident resident resident provide based on record revious Practitioner and failed to provide basid of 2 sampled resident (Residents #1 and #2 Resident #1's right look Resident #2's abdomisent to the hospital for	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of nensive person-centered			Preparation and/or execution of this Pl of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set for in the statement of deficiencies. This pl of correction is prepared solely because is required by the provision of the Federal & State Law.	of th lan e it	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С
		345155	B. WING _			07	/06/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				23	0 EAST PRESNELL STREET		
RANDOLF	PH HEALTH AND REI	HABILITATION CENTER		A	SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE
					DEFICIENCY)		
F 684	Continued From r	2000 20		20.4			
F 00 4	Continued From p	-	F	684			
		dy (IJ) began on 6/14/18 when			1. The plan of competing the execition		
		as not provided basic care and			1. The plan of correcting the specific	_	
		ff and live maggots were found			deficiency. The plan should address the	2	
		extremity wound. IJ began on			process that lead to the deficiency.		
		dent #2 when she was not			Posidont #1 was bosnitalized from		
provided with basic care and cleanliness by staff and live maggots were found in her abdominal folds. The Immediate Jeopardy was removed on 7/6/18 when the facility implemented a credible				Resident #1 was hospitalized from 6/27/18-7/6/18. On 7/7/18 Resident #1			
				has new orders for all wound treatment	to		
				and now has an additional PRN order t			
		moval. The facility will remain			ensure treatments can be scheduled	O	
	out of compliance at a lower scope and severity level of D (no actual harm with a potential for				based on residents preference. On July	<i>i</i> 6	
					2018 Licensed nurse completed a	, 0,	
		t is not Immediate Jeopardy) to			complete head to toe skin assessment	on	
		of systems are put in place			resident #1. No negative findings were		
		employee in-service.			observed as a result of the skin		
	-	h 1,7 11			assessment.		
	Findings included	:					
					On July 4, July 5, and July 6, 2018 the		
	1. Record review	revealed Resident #1 was			licensed nurse completed a complete		
	admitted to the fa	cility on 8/10/17 and readmitted			head to toe assessment of resident #2.	ı	
		esident was discharged back to			No negative findings were observed as	а	
	the hospital on 6/3	30/18 and remained in the			result of the skin assessment.		
	hospital during thi	s survey. The resident's					
	diagnoses include	ed; paraplegia, depression,			On July 5, 2018 resident #2 received		
		, schizophrenia, dependence on			shower with no negative findings noted	ı .	
	a wheelchair, pres	ssure ulcer (PU) of multiple					
		athy, Burkitt lymphoma (cancer			On July 4, 2018 the Director of Nursing	,	
		, peripheral arterial vascular			Assistant Director of Nursing, Staff		
	disease, and above	ve the knee amputation.			Development Coordiantor, Unit		
					Coordinator, Unit Managers, Nursing		
		ted 6/12/18 revealed Resident			Supervisor conducted an audit on 1009		
		an antibiotic for treatment of a			of residents to determine any residents		
		fection. The first dose of Zosyn			who routinely leave the center on Leav		
		ery 12 hours for 14 days was			absence and do not receive treatments	i	
		sident went LOA (leave of			due to LOA. All residents who have		
		/18 twice in his motorized			treatment orders in place and leave the	<i>:</i>	
		to town. Both LOAs the			facility LOA had their treatment orders		
		with his right lower leg/foot			updated to include PRN dressing chan		
	aressing missing.	When the resident returned to			to accommodate personal preferences		

Facility ID: 923001

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345155	B. WING		C 07/06/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/100/2010	
				230 EAST PRESNELL STREET		
RANDOLF	PH HEALTH AND REHA	BILITATION CENTER		ASHEBORO, NC 27203		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
F 684	Continued From pag	ge 21	F 684	Į.		
	the facility the secon	nd time, blood was dripping		and needs.		
	onto the floor (from t	the resident's right lower		On July 4, 2018 the Director of Nursin	g,	
		the facility hall way. The		Assistant Director of Nursing, Staff		
		ed that it was not safe for him		Development Coordinator, Unit		
	to continue to injure	his foot.		Coordinators, Unit managers and nurs	sing	
				supervisor completed head to toe		
		d 6/13/18 revealed the		assessments on 100% of the resident		
		o be non-compliant with		As a result of the skin assessments, n		
		sed to have wound dressings		other negative findings were observed	1.	
		n for the resident's refusal		On July 4, 2019 the Director of Nursin		
	was not documented	J.		On July 4, 2018 the Director of Nursin Assistant Director of Nursing, Staff	g,	
	A review of the out of	of facility release of		Development Coordinator, Unit		
		evealed Resident #1's last out		Coordinators, Unit managers and nurs	sing	
		/13/18. The resident left the		supervisor completed an audit on 100		
	_	day for the past 3 months.		residents to identify any residents who		
		•		refuse showers and bed baths as order		
	Resident #1's care p	olan dated review date		by the physician.		
	6/14/18 revealed go	als and interventions for daily				
	care decisions at tim	nes refuses wound treatment,		It is alleged that the facility failed to		
	independent with sn	noking, activities of daily living		provide basic care and cleanliness for	,	
		stive to care related to		Resident #1 and Resident #2.		
		k for falls, at risk for infection,				
	•	antipsychotic medication,		0.71		
		lyneuropathy, multiple PUs,		2.The procedure for implementing the		
		, and cellulitis of the right		acceptable plan of correction for the		
	•	e only intervention for wound		specific deficiency cited.		
	resident.	e was to encourage the		a)July 4, 2018, The Staff Developmen	. +	
	TOSIUCITI.			Coordinator (SDC),re-educated all		
	 Resident #1's quarte	erly Minimum Data Set dated		Licensed nursing staff to include full-ti	me.	
	6/14/18 revealed the resident had adequate			part-time, and PRN on interventions to		
		ch, and understood and		encourage compliance when resident		
		id intact cognition, no		refuse care and treatments. No licens		
	psychosis, and no behaviors. The resident			nurse will be allowed to work until the		
		extensive assistance for bed		education is completed. Newly hired		
	mobility and total de	pendence of two for transfer.		Licensed Nurses will be educated by	ihe	
	Locomotion on and	off the unit was supervision		SDC during their classroom orientatio		
	set-up only. Dressir	ng, personal hygiene, and		Licensed nurses will document reside	nts	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345155	B. WING_			0-	C 7/06/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01	700/2010	
					30 EAST PRESNELL STREET			
RANDOLF	PH HEALTH AND RE	HABILITATION CENTER			SHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL 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 684	Continued From p	page 22	Fé	684				
	·	person physical assistance and			refusals of showers, treatments, refusa	als		
	set up was for me			and any interventions attempted in a	110,			
	oot up was for me				progress note.			
	A nurses' note da	ted 6/14/18, written by the			h. ca. see			
	treatment nurse,							
	complained of inc	reased pain to his wounds.			3. The monitoring procedure to ensure	that		
	During dressing of	hange of the right lower			the plan of correction is effective and the	hat		
		revealed there was a large			specific deficiencies cited remains			
	amount thick, bro			corrected and/or in compliance with the	е			
		e moving in the wound. The NP			regulatory requirements.			
		ordered for the wounds to be			-\D-ik-M-ad Faidia the Olivia-I			
	l •	send the resident to the			a)Daily Monday - Friday in the Clinical			
	immediately trans	s called and the resident was			Morning Meeting for 12 weeks, the Director of Nursing, Assistant Director	of		
	ininiculately trans	merreu.			Nursing, Staff Development Coordinate			
	The hospital discl	narge summary dated 6/24/18			Unit Coordinators, Unit Managers will	J.,		
		t #1 was admitted on 6/14/18			audit Treatment Administration Record	ls of		
		s were acute cellulitis of the			residents identified as routinely going of			
	_	nity, acute pressure ulcer site not			LOA, and / or residents who routinely			
	specified, pressur	e ulcer of right leg, right above			refuse treatments. If concerns, such as	3		
		ion (AKA), Burkitt lymphoma,			not offering treatments at times suitabl			
		injury. Burkett lymphoma			meet the preference of the resident are	9		
		dent paralyzed due to spinal			identified, the affected resident will be			
		sident was treated for a urinary			interviewed to determine any change in			
		perative report for the right AKA			preferred time, physician's order obtain Treatment Administration Record upda			
		cumented that the residents right ad active infection with diffuse			and care plan updated as needed. If	iteu		
	edema.	ad active infection with diffuse			concerns such as non-compliance are			
	Cucina.				identified alternative interventions will I			
	A nurses' note da	ted 6/24/18 revealed Resident			attempted to encourage compliance. If			
	#1 returned to the	e facility with no pain and a			alternative interventions are not noted			
	wound vacuum to	his new AKA and several areas			attempted, the Licensed Nurse identific	ed		
		sident returned with orders for			as not having offered treatments at			
		tration to treat a urinary tract			different times or alternative intervention			
	infection.				to encourage compliance will be provide	bet		
	0 70//2 / 2 :=				a one to one re-education.			
		am an interview was conducted			B M E E E E E E E E E			
		nt Nurse (TN) who stated that			Daily Monday - Friday in the Clinical			
	iwo residents on I	Hall 700 had maggots. Resident			Morning Meeting for 12 weeks, the		1	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY MPLETED
		345155	B. WING_			C
NAME OF D	ROVIDER OR SUPPLIER	343133	B: Willo _	STREET ADDRESS, CITY, STATE, ZIP CO	•	7/06/2018
NAME OF PI	ROVIDER OR SUPPLIER				DE	
RANDOLF	PH HEALTH AND REHA	BILITATION CENTER		230 EAST PRESNELL STREET		
				ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From pag	e 23	F 6	84		
F 004	#1 had white moving bugs that were believed to be maggots coming out of his lower right extremity/foot wound with 100% necrotic tissue with recent diagnoses of vascular disease and he was sent immediately to the hospital. The resident also had a planned above the knee amputation pending which was performed on his last hospital admission. The resident was known to frequently leave the facility by motorized wheelchair in the extreme heat and go as far as 2 miles away to the store. There were times when the resident dragged his right foot while outside and his dressing came off and there were times when the resident refused to have his dressing changed putting him at higher risk for infection. The dressing to the right lower extremity was dressed as ordered and no other form of securing the dressing was done by the TN. The resident had to have his dressing redressed frequently due to falling off and drainage. The TN stated that the maggot issue information was passed verbally during shift change. On 7/5/18 at 8:05 am an interview was conducted with the facility Nurse Practitioner (NP) who		F 6	Director of Nursing, Assistar Nursing, Staff Development Unit Coordinators, Unit Mana audit Treatment Administratiresidents with physician ordeshowers or bed baths to valitreatments are offered as neon resident preference. If co as non-compliance are idential alternative interventions will to encourage compliance. If interventions are not noted at the Licensed Nurse identified having offered treatments at times or alternative interventions will be one to one re-education. b)The DON and/or the ADOI findings of audits monthly to Assurance Performance Imp (QAPI) Committee monthly find months for tracking and tren purposes with all follow up a determined by the QAPI teal	Coordinator, agers will on Records of ers for date eded based ncerns such tified be attempted alternative as attempted, d as not different tions to be provided a N will report the Quality provement for three ding ction	
	The resident was fre wound care dressing preferred his dressin	familiar with Resident #1. quently non-compliant with change. The resident g changes while still in bed		4.Title of person responsible implementing the acceptable		
	before he got up to his motorized wheelchair (WC). The NP stated from what she observed the resident would request to get up to his WC at various times and the dressing change time was not always altered to meet this schedule. The resident was alert and oriented. NP stated on			a) The DON and/or ADON we responsible for the implement acceptable plan of correction	ntation of the	
	6/13/18 she evaluate the dressing was soa drainage was like mu	ed the resident 's wound and		5.Dates when corrective acticompleted. The corrective actimust be acceptable to the St	ction dates	

OLIVILIV	OT OIL MEDIONILE G	WILDIO/ WD OLITATIOLO				CIVID ITC	7. 0000 000 1
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				_		(С
		345155	B. WING				06/2018
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DANDOI E	PH HEALTH AND REHAE	DII ITATION CENTED		2	30 EAST PRESNELL STREET		
KANDOLF	TO REALID AND REDAC	SILITATION CENTER		Α	SHEBORO, NC 27203		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG			IAG		DEFICIENCY)		
F 684	Continued From page	Continued From page 24					
	of arteries and veins)	of his lower extremities and			a)July 21, 2018		
	peripheral vascular d	isease (PVD) was found.					
	The NP commented t	that PVD can cause slow or					
	non-healing of wound	ds. The resident refused to					
	go to the Emergency	Department (ED) so the NP					
	ordered a broad-spec	ctrum antibiotic for					
		and labs and the wound care					
	· ·	NP commented that she					
	was surprised the res						
	6/14/18 when the Tre						
	resident's right lower						
	there were white mov						
		ots. The resident was					
		with his wound open to air eresident was informed and					
		e seriousness of his right leg					
	infection and then ag	9 9					
	_	ent had an above the knee					
		which was performed during					
	1	The resident had an intact					
	-	schizophrenia. The NP					
	stated that the reside	nt made poor choices. The					
	resident's only signific	cant other was in the facility					
		om his family. The NP					
		nt's right lower extremity					
	_	through from drainage and					
		f involved would talk to the					
		ite him when there were					
		ted she felt the resident					
		equences of refusal. The					
		d enough he would most					
		incompetent but was not competency evaluation. The					
		representative. The NP					
		as safe to leave the building					
	and had always retur	_					
	On 7/5/18 at 11:00 ar	m an interview was					
	conducted with the D	rirector of Nursing (DON)					

		(V1) PROVIDER/SURBURER/CUA	(V2) MI II	TIDLE	CONSTRUCTION	(X3) DATE	SLIDVEV
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	` ',	PLETED
			A. BUILD	_ טייי		,	C
		345155	B. WING			1	06/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	00/2010
					30 EAST PRESNELL STREET		
RANDOLF	PH HEALTH AND REHA	BILITATION CENTER			ASHEBORO, NC 27203		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF	Χ	(EACH CORRECTIVE ACTION SHOULD B		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ATE	DATE
					BET TOTETOT)		
F 684	Continued From pag	o 25		684			
1 001				004			
		dent #1 had a long history of personal care. The resident					
		his motorized wheelchair					
		e dressings to be changed					
	•	WC. The resident did not					
	_	the bed for wound care.					
		ent's WC for behavior					
	caused the resident's	s non-compliance to					
	increase. The reside						
	use, the WC was ret						
	compliance was 100						
	changing the resider	t's dressing on night shift					
		worked for a while with					
		e resident would change the					
		ound dressing changed					
	. •	eds and how he felt which					
		on breakdown between the					
		e resident should be offered					
	_	etting up to his WC. At times sk the night staff to place him					
		dressing were changed by					
		the WC the resident would					
		nanges unless he had a					
		nt was alert and oriented and					
	·	resentative. The resident					
	was asked each day	if he would allow wound					
	care. The DON state						
	interventions were no	ot always effective for this					
	resident and some of						
	·	stated a psychiatrist was not					
	obtained to evaluate						
	-	competency. The resident					
	had refused psychiat	try services in the past.					
	2. Resident #2 was a	admitted to the facility on					
	7/28/17. Diagnoses						
		at risk for falls, bowel					
	incontinence, and he						
	· ' · · · ·	. •	1		İ.		i .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345155	B. WING _			C 07/06/2018	
	ROVIDER OR SUPPLIER PH HEALTH AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	goals and interventi emotional and social desired to return to poor oral hygiene, of incontinence, hemip ulcer, and actual im The quarterly Minimarevealed the reside	ge 26 plan dated 4/27/18 revealed ons for dependent on staff for al needs, self-care deficit, home, fluid volume deficit, diabetes, at risk for falls, bowel plegia, potential for pressure pairment to skin integrity. num Data Set dated 5/24/18 nt had adequate hearing, clear nderstood and understands.	F 6	84			
	The resident had ar resident required expersons for all translocomotion. Dressi required 2 staff mer	n intact cognition. The stensive assistance of 2 sfers, bed mobility, and ng, bathing, and personal care mbers limited assistance. ed 6/19/18 at 3:31 pm, written rse, revealed the resident had					
	revealed anti-bacter A Nurse Practitione	r (NP) order dated 6/19/18 rial wash every day. r order dated 6/20/19 revealed ident to receive a shower					
	A nurses' note date resident had refuse showers and had re twice a week sched	ed 6/22/18 revealed the er every day was too much. ed 6/30/18 revealed the d some of her every day equested to go back to the ule. m an interview was conducted Nurse (TN) who stated that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345155	B. WING _		C 07/06/2018	
	ROVIDER OR SUPPLIER PH HEALTH AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 230 EAST PRESNELL STREET ASHEBORO, NC 27203		7700/2010
(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 684	#2 had several magg debris and two in the abdomen about 6/20 (NP) was notified and anti-bacterial wash we the resident refused assistants provided a wash. Nursing staff or refusal. On day 5 the maggots again in the fold. The TN stated the information was passed change. The staff was for maggots during refusal of the second incider and was not sure if the resident was found to of her lower abdomin the TN identified the and was not sure if the resident was always how maggots were a The NP was called alwash and shower earmaggots were found Administrator was very of the second incider expected the treatmed day to inform her if the ADON stated that the the Monday morning	she observed that Resident ots in her bed with food skin folds of her lower /18. The Nurse Practitioner d daily showers with ere ordered. By about day 3 her showers and the nursing a bed bath with anti-bacterial was not notified of the eresident had a few same area of her abdominal hat the maggot issue hed verbally during shift as verbally directed to look outine care. In an interview was esistant Director of Nursing hat Resident #2 had have maggots. The on have maggots in the folds all skin. The ADON stated maggots during treatment here was tissue injury. The dressed and it was unclear ble to get under her clothing. In dan order for anti-bacterial ch day was obtained. The on Sunday and the orbally informed on Monday have of maggots. The ADON hant nurse assigned for that here were any maggots. The maggots were mentioned in meeting but not discussed a process. The staff were	F 6	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345155	B. WING			C 07/00/2049	
NAME OF P	ROVIDER OR SUPPLIER	040100		STREET ADDRESS, CITY, STATE, ZIP COD		7/06/2018	
TO UNE OF TH	TO VIDER OR GOT FEILING			230 EAST PRESNELL STREET			
RANDOLF	PH HEALTH AND REHA	BILITATION CENTER		ASHEBORO, NC 27203			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From page	ge 28	F 68	84			
	On 7/3/18 at 5:45 pt with Resident #2 whincrease in the num 1 to 2 weeks ago. Tweek ago there wer and in her bed whico ordered anti-bacteri day which were still resident stated that the showers there whad hatched. The rand when she refus instead of a shower resident informed the shower. The resident the NP her lymph exiting the side of the NP her lymph exiting with the side of the NP her lymph exiting with the number of the side of the NP her lymph exiting with the number of the number o	m an interview was conducted to stated there was a quick ber of flies in her room about The resident stated about a re maggots on her stomach the caused her anxiety. The NP all wash and showers every in place at this time. The during the first five days of were additional maggots that esident preferred a bed bath the maggots returned. The re staff that she did not need a rent stated she was informed by dema can attract flies and agreed to have a shower.					
	with the NP who was #2. The resident was to make her own de own resident repress known to resist persided bath. Resident lateral lower abdom bed. The NP stated and cleanse with an resident agreed to owas provided why significant to the nursident she no long. The NP stated that the staff did not inforefusal on day three	m an interview was conducted is very familiar with Resident as alert and oriented and able ecisions. The resident was her entative. The resident was sonal care and preferred a #2 had maggots to her right inal fold and maggots in the inal fold and maggots again in inal fold and maggots and an inal fold and maggots and an inal fold and inal					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345155	B. WING _			C 07/06/2018
	ROVIDER OR SUPPLIER PH HEALTH AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203	•	01700/2010
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	were more effective and any potential fillike to transfer via the her size and fear of the shower refusal. edema which wept resident at increase. The NP stated that or treatment her ex re-educate the resident the refusal continuous attempted to ge make better choice consequences. The and sometimes it would not. On 7/5/18 at 10:45 conducted with Resident had a show made aware by the need for a shower of the staff used was over a five-damaggots and was woreturning. The resident to the show than the mechanical it was over a five-damaggots and was woreturning. The resident to the show than the mechanical it was over a five-damaggots and was woreturning. The resident to the show than the mechanical it was over a five-damaggots and was woreturning.	s, same place. The showers at washing the lymph edema by eggs. The resident did not the mechanical lift because of a falling which contributed to a resident refused care pectation was for staff to a dent to obtain compliance and a fall to a fall to a fall to be a fall to a fall to be a fall to a fal	F	584		
	Commented that the On 7/5/18 at 12:15 conducted with Nur stated that she was received a shower day. The resident p	edication. The resident e flies were better. pm an interview was sing Assistant (NA) #1 who assigned to Resident #2 who or complete bed bath every preferred a bed bath and had e her shower when it was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345155	B. WING _			l	06/ 2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	1 011	00/2010
RANDOLF	PH HEALTH AND REHAE	BILITATION CENTER		230 EAST PRESNELL STREET ASHEBORO, NC 27203			
(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 684	had seen flies in the more than usual. Wheresident to take a should and said she did not #1 provided a bed bashower order continushe would inform the resident refused a shower ordered as hower ordered with the Dwho stated that Residner ordered shower a called the resident to take a effective. The reside family member was cordered daily shower a shower and the nurresident a bed bath. called as an intervent receive a shower for shower and maggots expectation was for in the nurses of resident the nursing assistants of the refused shower and maggots were agresident on 6/23/18. The Administrator, As Corporate Nurse Corn Nursing were notified on 7/5/18 at 12:32 prints.	aware of the maggots and resident's room, but not nen the NP ordered for the ower, the resident refused need a shower anymore. NA th and later learned that the ed. NA #1 indicated that licensed nurse if the ower. In an interview was irector of Nursing (DON) dent #2 sometimes refused and the staff at times had family member to influence shower, which was not was in agreement that her stalled. On day three of the the resident refused to have sing assistant gave the The family member was not two days of the ordered daily appeared again. The DON's fursing assistants to inform the refusals and confirmed that is did not inform the nurses res, the NP was not aware, gain observed on the sesistant Administrator, insultant and Director of of the Immediate Jeopardy in.	F6	684			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345155	B. WING _			C 07/06/2018
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	CODE	07/06/2016
	10115211 011 001 1 2.2.1			230 EAST PRESNELL STREET	0002	
RANDOLF	PH HEALTH AND REHAE	BILITATION CENTER		ASHEBORO, NC 27203		
(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)		
F 684	Continued From page	e 31	F 6	584		
		g the specific deficiency es that lead to the deficiency				
	Health and Rehabilita paraplegia secondary was assessed as has Status (BIMS) score Minimum Data Set (Massessment reference 9/7/17, 10/20/17, 11/2 and 6/27/18. A BIMS resident is cognitively goes from 0-15, with possible score. Resident is cognitively goes from 0-15, with possible score. Resident is cognitively goes from 0-15, with possible score. Resident is cognitively goes from 0-15, with possible score. Resident including person and prissued an order by the 8/10/17 that he can be Absence (LOA) per the Resident #1 is current was care planned care including refusir care and personal hy LOA on 6/1/18, 6/8/18 two time 6/10/18 three times, 6/10/18 three times, 6/10/18, 6/9/18, 6/10/18 Resident #1 was out allow Licensed Nursident #1 was out allow Licensed Nursident #1	as admitted to Randolph ation on 8/10/17 due to 7 to Burkitt's lymphoma. He ring a Brief Interview Mental of 15 on the following MDS) Assessments with e dates of: 8/17/17, 8/24/17, 7/17, 2/7/18, 3/7/18, 6/14/18 ascore of 15 indicates the 7 intact. The BIMS scale 15 being the highest lent #1 is alert and oriented place. Resident #1 was e attending physician on eave the center on Leave of the resident's discretion. The hospital and the hospital are resident work as a few points of the going to bed, wound giene. Resident #1 went on 8/23/17 for declination of 19 of going to bed, wound giene. Resident #1 went on 8, 6/3/18, 6/4/18, 6/5/18, two times 18, 6/4/18 and 6/13/18. Of the center and did not 19 of the perform his treatment. Cititioner documented in				
	Venous Stasis Ulcer Resident #1 was beir for a right lower leg a	esident #1 was evaluated for of leg; per progress note ng evaluated by the surgeon mputation. On 6/11/18 a Skin Assessment was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50125			,	c	
		345155	B. WING			07/	06/2018	
	ROVIDER OR SUPPLIER PH HEALTH AND REHA	BILITATION CENTER	•	230	REET ADDRESS, CITY, STATE, ZIP CODE DEAST PRESNELL STREET SHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	findings per the residente center Wound Nowound to the right is ulcers 4.x5.25x0.1 1 undermining, pink word drainage, no odor, spain, Nurse Practitionstatus on 6/13/18. Care Nurse assesse perineum wound Stagranulation tissue, redrainage, normal ed Practitioner was mare 6/13/18. On 6/12/18 Nurse assessed Resthe right lower extree black necrotic tissue brown purulent drair notified and intramus 6/14/18 Resident #1 to have moving objeright lower leg. Reswas contacted and rothe Emergency Designation of the E	nsed Nurse with no abnormal dent's baseline. On 6/13/18 urse evaluated Resident #1's chium stage IV pressure 00% epithelialization, no ound bed, scant serous urrounding skin normal, no ner made aware of wound on 6/13/18 the center Wound of Resident #1 's Right age IV 4x5.75.1.2 100% and wound bed, small serous ges, no pain; Nurse de aware of wound Status on the center Wound Care sident #1 Arterial Wound to mity as 19.0x7x3.0cm, 100% as the center Wound Care scular antibiotic ordered. On was noted by charge nurse cts in his arterial wound to his ident #1 attending Physician esident was immediately sent epartment for evaluation of the true true of the center on wer leg amputation. Resident imergency Department on mitted with diagnosis of left ute kidney injury. Resident hospital.	F	684				
	Development Coord Managers and Socia 7/4/18 to review of the	virector of Nursing, Staff inator, Unit Coordinators, Unit al Services Director met on the medical record of Resident troot cause of the processes						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		345155	B. WING _			C 07/06/2018
	ROVIDER OR SUPPLIER PH HEALTH AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203	<u> </u>	01700/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	reviewed the number refusals of care related lower extremity, the Resident #1's right to could have come into during his thirteen pleased from the facility. The resident had refused right lower leg multipe 2018. During interviewas determined that coordinate Resident resident preference, identified right lower fallen off while outside and that facility did rewound dressing priofacility. b. Resident #2 was	iency cited. The team r of LOAs and the number of ted to treatments of the right center determined that ower leg arterial wound o contact with the maggots us incidence of being absent e center identified that I wound treatments to the ole times from June 1-13, ews with the facility staff, it	F	584		
	obesity, Chronic Obs Anxiety, Hemiplegia #1 BIMS on 5/24/18 on 4/5/18 was 15. C Assessment was pe noted. On 6/19/18 F have maggots to her #2's Nurse Practition for anti-bacterial was Resident #2's Nurse showers for Resident showers on 6/22/18, and 6/29/18. After no for Resident #2, noticare related to show	structive Pulmonary Disease, and Hemiparesis. Resident was 15. Resident #1 BIMS on 6/15/18, a Weekly Skin rformed with no findings Resident #2 was noted to abdominal folds. Resident her was notified with orders on received. On 6/20/18, Practitioner ordered daily at #2. Resident #2 refused 6/25/18, 6/26/18, 6/27/18 eview of the medical recording the number of refusals of ers, the center failed to interventions to get the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345155	B. WING _			C 07/06/2018	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 230 EAST PRESNELL STREET ASHEBORO, NC 27203	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From page	ge 34	F	684			
	to review of the med determine the root of lead to the deficience. Analysis was conducted Team (IDT) on 7/5/12 there was not a resignate intervention promote the likeliho with showers per philipped determined the centresident on the risks including risk of mage evaluation assessm. Nurse assigned to Fill were no signs of mage unit Coordinator into regarding her bed by concerns with bed to the signal of the						
	plan of correction for On 7/4/18 Assistant Director or Coordinator, Unit Core 11 Nurse Supervisor audits to determine leave the center on treatments due to the On 7/5/18 Assistant Director or Coordinator, Unit Core 11 Nurse Supervisor physician and order	the Director of Nursing, f Nursing, Staff Development coordinators, Unit Managers, 3- r will contact the attending s will be requested to offer neduled as needed based on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345155	B. WING			C 07/06/2018	
	ROVIDER OR SUPPLIER PH HEALTH AND REHAE			STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203	•	1//06/2016	
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Assistant Director of Coordinator, Unit Co- 11 Nurse Supervisor nurses regarding reir needed when resider to protect the wound - On 7/5/18 th Assistant Director of Coordinator, Unit Co- 11 Nurse Supervisor audits to determine a showers and bed bat 7/5/18 the attending by the Director of Nu Nursing, Unit Coordin clarification of any refor showers and bed or bed bath to be schresident preference. All residents in the coassessment complete Coordinators, Unit M Nurse, Treatment Nu Nursing; no other reshaving maggots. Beginning 7/5/18 the Assistant Director of Coordinator, Unit Co- 3-11 Nurse Supervisor Supervisor educated a physician's order to scheduled as needed or who refuse treatment.	ne Director of Nursing, Nursing, Staff Development ordinators, Unit Managers, 3- begin in-servicing the facility inforcing wound dressing as int going on leave absences bed. In e Director of Nursing, Nursing, Staff Development ordinators, Unit Managers, 3- conducted medical record inty residents who refuse this per physician order. On physician will be contacted ring, Assistant Director of inators and Unit Managers for sidents with physician orders baths in order for the shower meduled at a time based on enter had a head to toe skin ed on 7/4/18 by the Unit anagers, Wound Care irse and Assistant Director of sidents were identified as Director of Nursing, Nursing, Staff Development ordinators, Unit Managers, or and 11-7 Nurse the licensed nurses to seek offer treatments to be d based on resident ints who routinely go on LOA	F 6	84			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345155	B. WING _				C 06/2018
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 230 EAST PRESNELL STREET)E		
				ASHEBORO, NC 27203			
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 684	Continued From page	e 36	F 6	684			
	Coordinators, Unit Ma Supervisor and 11-7 the licensed nurses b	Nurse Supervisor educated eginning 7/5/18 to reinforce when residents go on LOA					
	Nursing, Staff Develor Coordinators, Unit Massupervisor and 11-7 the licensed nurses be the status of the treat residents return from abnormal findings in The Director of Nursing, Staff Develor Coordinators, Unit Massupervisor and 11-7 the licensed nurses be needed dressing chalicensed nurse will perform the supervisor and 11-7 the licensed nurse will perform the license of the li	Nurse Supervisor educated eginning 7/5/18 to evaluate ment or dressing when LOA and document any Resident Progress Notes. ng, Assistant Director of pment Coordinator, Unit anagers, 3-11 Nurse Nurse Supervisor educated eginning 7/5/18 that if an as					
	Resident Progress Nobed or amount of dra Director of Nursing, A Staff Development Co Coordinators, Unit Ma Supervisor and 11-7 the licensed nurses on the licensed nurse will do dressing change on the Record. The Director of Nursing, S Coordinator, Unit Coordinator, Unit Coordinator, Unit Coordinator, Supervisor educated	otes if changes in the wound inage are noted. The assistant Director of Nursing, coordinator, Unit anagers, 3-11 Nurse Nurse Supervisor educated eginning 7/5/18 if an asinge is indicated, the icument the treatment or the Treatment Administration of Nursing, Assistant Staff Development ordinators, Unit Managers, or and 11-7 Nurse					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3)	(X3) DATE SURVEY COMPLETED	
		345155	B. WING _			C 07/06/2018	
	ROVIDER OR SUPPLIER PH HEALTH AND REHA	BILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZI 230 EAST PRESNELL STREET ASHEBORO, NC 27203	IP CODE	0110012010	
(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 X (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	be notified of any ch documented in the F The Director of Nurs Nursing, Staff Devel Coordinators, Unit M Supervisor and 11-7 the licensed nurses complying with phys bed baths including to encourage reside approaches on Trea and / or Resident Pr Nurse will be permitt receiving the educat were re-educated by Assistant Director of Coordinator, Unit Co 3-11 Nurse Supervisor beginning resident refuses a be Charge Nurse is to be Beginning 7/5/18 no allowed to work with education. Of the 48 Licensed I Nurses have received the education as is. Three of the to receive the education Act (FMLA). Each of have not yet received the received the education and yet received the education.	ed, the attending physician will ranges with the notification Resident Progress Notes. Sing, Assistant Director of opment Coordinator, Unit Managers, 3-11 Nurse Yourse Supervisor educated beginning 7/5/18 related to ician's orders for showers or using alternative approaches nt compliance and document toment Administration Record ogress Notes. No Licensed ted to work without first ion. The Nursing Assistants of the Director of Nursing, Staff Development pordinators, Unit Managers,	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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		345155	B. WING			07/	06/2018
	ROVIDER OR SUPPLIER PH HEALTH AND REHA	BILITATION CENTER		230 E	EET ADDRESS, CITY, STATE, ZIP CODE EAST PRESNELL STREET IEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	the Staff Developme classroom orientation order to offer treatments order to offer treatments and treatments; reinforce residents go on LOA removed; comply with showers or bed bath approaches to encount and document approaches to encount and document approaches; evaluate the dressing when resid document any abnormal progress Notes; that change is indicated, perform the dressing status of the wound Notes if changes in the drainage are noted; or drainage are noted be notified of any change and treatment of the complision will be complysician will be complysician will be complysician and treatment of correction is effect deficiency cited remains and the staff of the compliance with the	d Nurses will be educated by int Coordinator during their in to: to seek a physician's ents to be scheduled as sident preference for ely go on LOA or who refuse e dressings as needed when a due to risk of dressing being ith physician's orders for is including using alternative burage resident compliance baches on Treatment or and / or Resident Progress status of the treatment or ents return from LOA and it if an as needed dressing the licensed nurse will in the Resident Progress the wound bed or amount of if changes in the wound bed in the attending physician will anges with the notification Resident Progress Notes. The sident #1's attending intacted to request a coffer treatments to be do based on resident ments will be reinforced as	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345155	B. WING				C 06/2018
	ROVIDER OR SUPPLIER PH HEALTH AND REHA	ABILITATION CENTER	•	230	REET ADDRESS, CITY, STATE, ZIP CODE DEAST PRESNELL STREET SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Assistant Director of Coordinator, Unit Cowill audit Treatment residents identified and / or residents with treatments. If concitreatments at times preference of the reaffected resident with any change in preference of the reaffected resident with any change in preference of the reaffected resident with any change in preference of the reaffected resident with any change in preference of the reaffected resident with any change in preference on concerns such as malternative interventions are not be provided a one to one of the provided and the provided a one to one of the provided a one to one of the provided and the pr	ks, the Director of Nursing, of Nursing, Staff Development coordinators, Unit Managers at Administration Records of as routinely going on LOA, who routinely refuse erns, such as not offering suitable to meet the esident are identified, the suitable to meet the erred time, physician's order at Administration Record control and updated as needed. If non-compliance are identified ations will be attempted to noted as attempted, the entified as not having offered ent times or alternative courage compliance will be one re-education. It is in the Clinical Morning ks, the Director of Nursing, of Nursing, Staff Development coordinators, Unit Managers at Administration Records of ician orders for showers or the treatments are offered as esident preference. If non-compliance are identified tions will be attempted to note. If alternative on toted as attempted, the entified as not having offered entitimes or alternative courage compliance will be	F	684			

PRINTED: 08/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SURVEY COMPLETED	
	345155	B. WING				C 06/2018
	ILITATION CENTER		23	30 EAST PRESNELL STREET	1 077	00/2010
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	1		,		(X5) COMPLETION DATE
The Title of the person implementing the accomplementing the Afor implementing the Immediate Jeopardy Validation: Immediate Jeopardy at 4:15 pm validation credible allegation for interviews of one lice assistant for each of evidence of in-service and maintaining a cle completed for 123 states 56 staff members on am outside profession observed to treat the spray. On 7/6/18 at 9 stated that the facility for flies. Maintains Effective P CFR(s): 483.90(i)(4) §483.90(i)(4) Maintai program so that the facility for flies. This REQUIREMENT by: Based on observation Practitioner (NP) interviews the facility effective pest control presence of flies in the (12) sample residents #5). Residents #1 has	n responsible for eptable plan of correction: dministrator is responsible plan of correction. removal date: 7/6/18 (IJ) was removed on 7/6/18 was completed of the IJ removal as evidenced by need and one nursing the 7 facility halls for ecompletion. Pest control an facility in-service was aff members on 7/2/18 and 7/3/18. On 7/6/18 at 8:00 hal pest control was facility grounds with a liquid 0:30 am the Administrator and grounds were treated est Control Program In an effective pest control acility is free of pests and This is not met as evidenced one, record review, Nurse review, resident and staff failed to implement an program to contain the erooms of four (4) of twelve is. (Residents #1, #2, #3, and id live maggots develop in his			of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set for in the statement of deficiencies. This pl of correction is prepared solely becaus	lan of th lan e it	7/21/18
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page The Title of the perso implementing the acc The Nursing Home Act for implementing the Immediate Jeopardy Validation: Immediate Jeopardy at 4:15 pm validation credible allegation for interviews of one lice assistant for each of the evidence of in-service and maintaining a cle completed for 123 sta 56 staff members on am outside profession observed to treat the spray. On 7/6/18 at 9 stated that the facility for flies. Maintains Effective PCFR(s): 483.90(i)(4) §483.90(i)(4) Maintain program so that the facility for flies. This REQUIREMENT by: Based on observatio Practitioner (NP) intelemental interviews the facility effective pest control presence of flies in the (12) sample residents #5). Residents #1 had	ASSISTANT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 The Title of the person responsible for implementing the acceptable plan of correction: The Nursing Home Administrator is responsible for implementing the plan of correction. Immediate Jeopardy removal date: 7/6/18 Validation: Immediate Jeopardy (IJ) was removed on 7/6/18 at 4:15 pm validation was completed of the credible allegation for IJ removal as evidenced by interviews of one licensed and one nursing assistant for each of the 7 facility halls for evidence of in-service completion. Pest control and maintaining a clean facility in-service was completed for 123 staff members on 7/2/18 and 56 staff members on 7/3/18. On 7/6/18 at 8:00 am outside professional pest control was observed to treat the facility grounds with a liquid spray. On 7/6/18 at 9:30 am the Administrator stated that the facility and grounds were treated for flies. Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced	A BUILDI 345155 B. WING. ROVIDER OR SUPPLIER PH HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 The Title of the person responsible for implementing the acceptable plan of correction: The Nursing Home Administrator is responsible for implementing the plan of correction. Immediate Jeopardy removal date: 7/6/18 Validation: Immediate Jeopardy removal date: 7/6/18 at 4:15 pm validation was completed of the credible allegation for IJ removal as evidenced by interviews of one licensed and one nursing assistant for each of the 7 facility halls for evidence of in-service completion. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 20 EAST PRESNELL STREET ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION) Continued From page 40 The Title of the person responsible for implementing the acceptable plan of correction: The Nursing Home Administrator is responsible for implementing the plan of correction. Immediate Jeopardy (IJ) was removed on 7/6/18 at 4:15 pm validation was completed of the credible allegation for I J removal as evidenced by interviews of one licensed and one nursing assistant for each of the 7 facility halls for evidence of in-service completion. Pest control and maintaining a clean facility in-service was completed for 123 staff members on 7/3/18. On 7/6/18 at 9:30 am the Administrator stated that the facility and grounds were treated for files. Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) S483.90(i)(4) Maintain an effective pest control programs to that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, Nurse Practitioner (NP) interview, resident and staff interviews the facility failed to implement an effective pest control program so that the facility failed to implement an effective pest control program to contain the presence of flies in the rooms of four (4) of twelve (12) sample residents. (Residents #1, #2, #3, and #5). Residents #1 had live maggots develop in his is required by the provision of the Fede	A BUILDING 345155 B. WING STREET ADDRESS, CITY, STATE, 2IP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICEMENC MS) THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 Continued From page 40 The Title of the person responsible for implementing the plan of correction: The Nursing Horne Administrator is responsible for implementing the plan of correction. Immediate Jeopardy (IJ) was removed on 7/6/18 at 41-15 pm validation was completed of the credible allegation for IJ removal as evidenced by interviews of one licensed and one nursing assistant for each of the 7 facility halls for evidence of in-service completion. Pest control and maintaining a clean facility in-service was completed for 123 staff members on 7/2/18 and 56 staff members on 7/3/18. On 7/6/18 at 8:00 am outside professional pest control was observed to treat the facility grounds with a liquid spray. On 7/6/18 at 9:30 am the Administrator stated that the facility and grounds were treated for flies. F 925 F 925 F 925 F 926 F 927 F 927 F 927 F 928 F 928 F 928 F 929

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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		345155	B. WING		0	7/06/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
DANIBOLI		LABULITATION OF NITED		230 EAST PRESNELL STREET			
RANDOLI	TH HEALIH AND REP	HABILITATION CENTER		ASHEBORO, NC 27203			
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 925	Continued From p	age 41	F 92	25			
	Resident #1 was t	lop in her abdominal folds. ransferred to the hospital for		F925			
	treatment for mag	,		1.The plan of correcting the deficiency. The plan should process that lead to the defi	address the		
Immediate jeopardy (IJ) began on 6/14/18 who Resident #1 was found with live maggots in hi				process that lead to the den	Cicricy.		
		ity wound. Immediate Jeopardy		On 6/14, Resident #1 was tr	ransferred to		
		for Resident #2 when live		the hospital.			
	maggots were fou	nd on her abdomen. The facility					
	•	t an effective pest control		On 6/15 Resident #1's room	•		
	1	I flies in the facility to prevent			cleaned and disinfected by Housekeeping		
		of maggots on Resident #1 's		Staff.			
		sident #2 's abdomen. The		On 6/20 Resident #2 receive	ad naw arders		
	1	dy was removed on 7/6/18 mplemented a credible		from Nurse Practitioner for o			
		noval. The facility will remain		IIOIII Nuise Fractitioner for t	Jally SHOWEIS.		
	_	at a lower scope and severity		On 6/20/18 Maintenance Di	rector		
		al harm with a potential for		conducted audit on all fly fai			
		is not Immediate Jeopardy) to		operations. As a result of the			
		of systems are put in place		were no negative findings a			
		mployee in-service.		were operating normally.	•		
	Findings included:			On 6/21/18 Maintenance Di all fly lights and replaced sti			
		quarterly Minimum Data Set ealed the resident had adequate		needed.			
		ech, and understood and		On 7/2/18 Assistant Adminis	strator,		
		had intact cognition, no		Maintenance Director, Main			
	psychosis, and no	behaviors.		Assistant completed an aud	it of 100% of		
				facility windows to ensure w	indows closed		
	A nurses' note da	ted 6/14/18, written by the		and latched properly and co			
	Treatment Nurse ((TN), revealed Resident #1 was		result of the audit, 1 room w	•		
	observed to have	white moving objects coming		of compliance and was repa	aired by		
		er extremity wound. The NP		Maintenance Director on 7/2	2/18.		
	was informed and	an order to transfer the					
	resident to the hos	spital and to leave the wound		On 7/2/18 Assistant Adminis			
	open to air was ob	otained.		Maintenance Director, Main			
				Assistant completed an aud	it of 100% of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345155	B. WING_			0	7/06/2018	
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				23	0 EAST PRESNELL STREET			
RANDOLF	PH HEALTH AND REI	HABILITATION CENTER		AS	SHEBORO, NC 27203			
(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)		(X5) COMPLETION DATE	
	1				,			
F 925	Continued From p	page 42	F 9	925				
		note dated 6/14/18 revealed hospitalized on 6/14/18 for right			facility windows screens for integrity at quality. As a result of the audit 22 scre			
	lower extremity w	ound infection and white moving			had minor holes in screen. Maintenand			
	objects in his wou	ind. The Nurse Practitioner			Director and Maintenance Assistant			
		he resident's right lower			repaired all screens on 7/2, 7/3 and 7/5	5.		
		g to be removed and left open to						
		the hospital. The resident was			On 7/4/18 the Director of Nursing,			
	transported by En	nergency Medical Services.			Assistant Director of Nursing, Staff			
	A 11it-1-ii				Development Coordinator, Unit			
		rge summary dated 6/24/18			Coordinators, Unit Managers, and Nur			
		t #1 was admitted on 6/14/18 for			Supervisor completed head to toe skin assessments on 100% of the residents			
	an above the kne	right lower extremity and had			assessments on 100% of the residents	> .		
	an above the kne	е апритатоп.			On 7/6/18 Contracted Pest Control			
	On 7/3/18 at 9:45	am an interview was conducted			Company provided pest control treatm	ent		
		TN stated that on 6/14/18 during			to exterior and interior of facility.	O. I.		
		sident #1's right lower extremity						
		ects were observed coming out			Effective 7/6 facility added fly program	to		
		ch staff and the NP believed to			current contract with Pest Control Serv			
	be maggots. The	resident was sent immediately			Provider. This program includes month	ıly		
	to the hospital.				treatment of interior, exterior and exter	ior		
					campus of facility.			
		vealed Resident #1 was						
		6/27/18 and was not available			On 7/5 the Assistant Administrator			
	for interview or ob	servation during the survey.			educated Maintenance Director and			
	4h Daview of a s	westers Minimerum Data Cat			Maintenance Assistant on Notification			
		uarterly Minimum Data Set			Pest Control services when an increas	e or		
		./18 revealed Resident #2 had , clear speech, and was			pest activity is observed.			
		nderstands. The MDS specified			On 7/5 the Assistant Administrator			
		an intact cognition.			educated Maintenance Director and			
	rooidont nad t				Maintenance Assistant on checking fly			
	A nurses' note da	ated 6/19/18 at 3:31 pm, written			lights twice monthly for three months t			
		nurse, revealed the resident had			monthly thereafter.			
	maggots in her at				•			
					On 7/6 Assistant Administrator Educat	ed		
	On 7/3/18 at 9:45	am an interview was conducted			Maintenance Director and Maintenance	е		
		t Nurse (TN) who stated that on			Assistant on the addition of the fly			
	6/19/18 she went	to place Nystatin powder to			program to the facility's contract for Pe	st		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345155	B. WING				С
NAME OF D	DOVIDED OD CUIDDUED	343133	B. WINO		TREET ADDRESS, CITY, STATE, ZIP CODE	07/	06/2018
NAME OF PR	ROVIDER OR SUPPLIER				, , ,		
RANDOLP	H HEALTH AND REHA	BILITATION CENTER			30 EAST PRESNELL STREET		
				Α	SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 925	Continued From pag	ne 43	F	925			
. 020			'	323	Control Comitoes		
		minal folds and noticed 2			Control Services.		
		fold of her lower right lateral			On 7/5/40 the Meintenan Director		
		aggots in the bed. The TN			On 7/5/18, the Maintenance Director Activated the 700 Hall Exit Door Alarm		
		the NP who ordered daily ibacterial wash to remove the					
		eggs. The TN was not aware			and removed alarm reset key. Staff will have to contact maintenance in order to		
	,	service visit for the flies after				J	
	identifying the magg			reset alarm.			
	identifying the mage	jots.					
	On 7/3/18 at 5:45 no	m an interview was conducted			2.The procedure for implementing the		
	with Resident #2 who stated recently there was a			acceptable plan of correction for the			
			mber of flies in her room specific deficiency cited. The resident was killing				
	•						
		a fly swatter and would ask					
		its to assist. The number of			Assistant Director of Nursing, Staff		
	-	s an increase. The resident			Development Coordinator, Unit		
	stated other than the	e fly swatter she was not			Coordinators, Unit Managers and Nurs	ing	
		ethod to control the flies in her			supervisor educated 100% of staff to		
	room. The resident	stated that she complained to			include full-time, part-time, and weeker	ıds	
	the nursing assistan	ts on more than one			on not using the 700 hall exit and the		
	occasion. The resid	lent stated about a week ago			process of reporting flies if observed in		
	there were maggots	on her stomach and in her			resident rooms. This in-service also		
	bed. The resident st	ated that she had a daily			included filling out a work order if any		
		pacterial wash to prevent any			window screens are damaged.		
	further maggots or h	natching of eggs and no					
		. She further stated that			On 7/5/18 the Director of Nursing,		
		id not approach her to inquire			Assistant Director of Nursing, Staff		
		k her window or provide any			Development Coordinator, Unit		
	•	ontrol other than what was			Coordinators, Unit Managers and Nurs	ing	
	already in place.				supervisor educated 100% of staff to		
	4. Davidson (C)	eta ela Minima de Data Cart			include full-time, part-time, and PRN or	1	
	•	rterly Minimum Data Set			maintaining a clean facility.		
	• •	8 revealed Resident #3 had			7/E/10 the Director of Neuroing Assistan	.4	
		lear speech, and was			7/5/18 the Director of Nursing, Assistar		
		lerstands. The MDS specified			Director of Nursing, Staff Development		
	the resident had an	madi dognillon.			Coordinator, Unit Coordinators, Unit		
	On 7/2/19 at 0:45 at	m an observation of Posident			Managers and Nursing supervisor		
		m an observation of Resident			educated 100% of staff to include		
	#3 \$ 100111 (R0011) #4	112) was completed. The			full-time, part-time, and PRN on the life		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345155	B. WING _				C / 06/2018	
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	00/2010	
				23	30 EAST PRESNELL STREET			
RANDOLF	PH HEALTH AND REHA	BILITATION CENTER		A	SHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 925	Continued From pag	e 44	F 9	925				
	resident's bed was no were a few flies note. The room and the resident was no odor. I and on the bed and The resident was ob mobility and no ability. On 7/2/18 at 9:45 and with Resident #3 who flies and believed the window where the 2 met. The fly increas recent. The resident swatter. On 7/2/18 at 9:55 and with Nurse #1 who we would have the window where the 2 met. The resident swatter.	ext to the window. There ad flying around the resident. sident were both clean and The flies were observed to the resident's hand and face. served to have limited by to swat the flies away. In an interview was conducted to stated he did not like the teley were coming in the sliding window glass pieces the in flies in his room was the stated he could not use a fly In an interview was conducted that assigned to Resident #3. It last Tuesday she informed the flies and the residents that the sidents that the siden			cycle of a fly and how to identify flies a maggots. 3. The monitoring procedure to ensure the plan of correction is effective and the specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. Beginning 7/5/18, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Social Worker, Medical Records Coordinator, Business Office Director, Admissions Coordinator, Maintenance Director, Human Resources Coordinator, Unit Managers, Unit Coordinators, Transportation Director, Activity Assistant Scheduler will perform and audit of two rooms twice a week for presence of flies. These audits will continue for 12	that nat e or,		
	believe that a fly swaresident who did not swatter such as Res that flies were in Reshallway during the in On 7/3/18 at 8:55 and with Resident #3 who had been in to evaluate something to the wire The flies were better 1d. Review of a qualidated 6/15/18 reveal adequate hearing, clients	atter was effective for a have the ability to use the ident #3. Nurse #1 noted sident #3's room and in the atterview. In an interview was conducted to stated that maintenance ate his window, did adow and killed some flies. Interly Minimum Data Set led Resident #5 had lear speech, and was erstands. The MDS specified			weeks. Fly lights will be audited by the Maintenance Director, Maintenance Assistant or Assistant administrator twi monthly for three months and monthly thereafter, or as indicated. Maintenance Director, Assistant Maintenance Director or Assistant Administrator will accompany Pest Cor Technician during monthly and as need visits/treatments for a minimum of three months to validate services rendered. Results of these audits will be presented by the Maintenance Director, Assistant Administrator or Administrator for review.	ntrol ded e		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345155	B. WING _				06/2018
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	00/2010
				23	30 EAST PRESNELL STREET		
RANDOLF	PH HEALTH AND REHAE	SILITATION CENTER			SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 925	that he had several fl not like flies. He furth in flies in his room wa know why. The resid to swat the flies. On 7/2/18 at 11:40 ar of room #712 (Reside were observed in the closed completely an seen at the window's On 7/2/18 at 10:10 ar conducted with the H who stated that hous report concerns of flie were the usual numb no concerns were report concerns were report concerns were report to the Maintenance on 6/20/18 he was all and investigated. Min measures to control from and no new intervent control was schedule when called on an as on 6/20/18 that he kill informed of the flies are sidents that were a felt that the entry for the doors for staff and vis recent heavy rain with and humidity that cau enter the facility. Min	m an interview was lent #5. Resident #5 stated lies in his room and he did her stated that the increase as recent and he did not lent stated he was not able m an observation was done ent #5's room) and 2 flies room. The window was not d light from outside could be edge. m an interview was ousekeeping Manager (HM) ekeeping was required to les. The HM stated that there er of flies in the facility and borted. an interview was conducted Manager (MM) who stated lerted to flies on Hall #400	FS	925	in Quality Assurance and Performance Improvement Committee monthly for a minimum of three months to validate success of the interventions and recommendations of Quality Assurance and Performance Improvement Committee to assure compliance is sustained ongoing. 4. Title of person responsible for implementing the acceptable POC. a) The Maintenance Director and/or Administrator and/or Assistant Administrator will be responsible for the implementation of the acceptable plan correction. 5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a) July 21, 2018	e e of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345155	B. WING		07/06/2018	
	ROVIDER OR SUPPLIER PH HEALTH AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203	1 07/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE COMPLETION	
F 925	for pest control to p He explained that o not identified. All po of were evaluated a the entry/exit doors control will be evalu result of inquiry. The change. MM stated #718 complained of killed the flies, not s commented that Ha the other halls. On 7/3/18 at 10:30 conducted with MM known maggots tha Administrator of two two residents had n and to evaluate for to residents. MM si maggots on residen MM stated that on h than on other halls the sticky paper in t to call for the outsid requested HM to ha room deep cleaned for flies and did not that was why he did pest control compan plan was to abate fl kill the flies in the fa commented that the or sprays but pest of	ge 46 e. MM stated he did not call rovide service to the facility. In particular root cause was obtentials that MM was aware and the only one identified was. MM stated outside pest sating the fly issue today as a set fly issue was a quick at that the resident in Room of flies and MM swatted and sure the total amount. MM stated after disclosure of the was informed by the consequence occasions where the past 2 weeks potentially more flies relating the bug light and decided not the pest control. MM stated he bug light and decided not be pest control. MM stated he heave the resident with maggot's and the the resident with maggot's and the observed see any more than usual and anot request for the outside my to provide service. MM's ites that come in the door and incility by fly swatter. MM are facility cannot use chemicals control can. MM commented at the situation warranted pest	F 925			
	control. Pest control month for preventio	of the situation warranted pest of treated the facility once a n that was not specific to flies. elt the facility's current fly				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345155	B. WING		C 07/06/2018	
	ROVIDER OR SUPPLIER PH HEALTH AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203	1 0110012010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR 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 925	MM then stated that informed him of the maggots the circum did not employ the the facility. MM state management was less to conducted with the (ADON) who was a maggots on their beand one resident with the their composition of the less to kill flies. Staff rown management of an maintenance. The Administrator, Corporate Nurse Corporate States and the circumstance of the less thanks and the less thanks and the less thanks and the less thanks are the less thanks ar	and an interview was Assistant Director of Nursing was transferred to the hospital. The NP was notified was cleaned and no erved. The staff were informed and swere required to notify y fly concerns and to inform Assistant Administrator, consultant and Director of ed of the Immediate Jeopardy	F 92	,		
	allegation for imme 7/6/18 which include The plan of correct including the proceduted: On 6/14/18 at appropriate Maintenance Direct the wound of Residute to the room and visit maggots. At that tirphysician order was	d an acceptable credible ediate jeopardy removal on led the following: ing the specific deficiency esses that lead to the deficiency eximately 11:30 am, the stor was notified of maggots in lent #1. He immediately went sually checked for any signs of me none were identified. A s obtained and Resident #1 spital for evaluation. On				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345155	B. WING _			C 07/06/2018
NAME OF PROVIDER OR SUPPLIER RANDOLPH HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203	<u> </u>	0170012010
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 925	Housekeeping Supclean Resident #1 ' precaution. The roc cleaned on 6/14/18 identified. Pest Cor 6/14/18. On 6/19/18 Resider maggots on her above was deep cleaned a noted on her over be properly stored. Restorage bags to see admitted to center of including, but not lir Chronic Obstructive Hemiplegia and He Weekly Skin Assess findings noted. On noted to have magge Resident #2 Nurse orders for Hibiclens Resident #2 Nurse Showers. Resident #2 refused 6/25/18, 6/26/18, 6/26/18, 6/review of the medicanoting the number of showers, the center interventions to end with the physician ' The breakdown in the Maintenance Di Pest Control Compathe Maintenance Di Pest Control Compat	ance Director notified the ervisor of the need to deep is room as an added in was thoroughly deep with no signs of maggots introl came to center on the state was noted to have domen. At that time her room as there was spoiled food in ed table as well as food not esident #2 was provided for the sure her food. Resident #2 was no 7/28/17 with diagnosis in the sure her food. Resident #2 was no 1/28/17 with diagnosis in the sure her food. Resident #2 was no 1/28/18 as sment was performed with no 6/19/18 Resident #2 was gots to her abdominal folds. Practitioner was notified with 4% received. On 6/20/18 Practitioner ordered Daily It showers on 6/22/18, 27/18 and 6/29/18. After all record for Resident #2 of refusals of care related to failed to implement specific sourage the resident to comply	F 9	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345155	B. WING _			C 07/06/2018	
NAME OF PROVIDER OR SUPPLIER RANDOLPH HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 925	Continued From page		F 9	25			
	one in-service educe Director regarding is Control Company at that can potentially in the Nursing Home A Nursing, Maintenan Set Coordinators, S Nurse Supervisor in the root causes the breakdown. One of by the IDT was there Maintenance Director Company to perform again on 6/22/18 with the center. Another the IDT was flies en using the 700 hall ean air curtain. The	Care Team (IDT) including administrator, the Director of the Director, Minimum Data ocial Workers and Evening the on 7/5/18 and determined pest control program the Root Cause determined					
	Maintenance Direct Maintenance Assista Pest Control to come treatment as indicated notifications of pests Maintenance Direct 700 Hall exit door to utilized for non-eme Cause determined of through tears in the Assistant Administral audit for screen inter	ants on 7/5/18 to notify the e do a center visit and ed when any observations or soccur. On 7/5/18 the or activated an alarm on the alert if when the door is regencies. Another of the Root was flies entered the center window screens. The ator conducted a 100% facility grity on 7/2/18. On 7/2/18 the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION IG	` '	(X3) DATE SURVEY COMPLETED	
		345155	B. WING			C 7/06/2018	
NAME OF PROVIDER OR SUPPLIER RANDOLPH HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 230 EAST PRESNELL STREET ASHEBORO, NC 27203		07/06/2018 DE			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 925	The Nursing Home A Maintenance Director Maintenance Assistate Pest Control to come treatment as indicate notifications of pests Administrator educate and one of two Mainthat fly sticky paper of changed as needed months and monthly The remaining Maintwacation and is scheen 7/10/18. On 7/10/18 Assistant will be educed to come do as indicated when a notifications of pests paper should be cheneded twice month monthly thereafter, on the Pest Control Contr	replementing the acceptable the specific deficiency cited: Administrator educated the or and one of two ants on 7/5/18 to notify the edo a center visit and ed when any observations or occur. The Nursing Home ted the Maintenance Director tenance Assistants on 7/5/18 should be checked and twice monthly for three thereafter, or as indicated. The tenance Assistant is on duled to return to work on the remaining Maintenance cated to notify the Pest a center visit and treatment my observations or occur and that fly sticky ocked and changed as ly for three months and	F9	,			
	on 7/6/18. On 7/6/18 the Pest 0 monthly exterior bait Pest Control visits a monthly basis and w per monitoring regim	Control Company added service for flies. Indicate the center on a fill visit and treat as needed lien. Inthly visits will not have a gap					

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345155	B. WING _			C 07/06/2018
NAME OF PROVIDER OR SUPPLIER RANDOLPH HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203		0770072010
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 925	the potential to be a Maintenance Direct rooms on his Amba obtain a fly-swatter and killed both flies designed to enhance responsiveness three residents by facility Ambassador includents and perform residents and perform residents observations two times a week or more and perform residents observations two times and perform residents observations two times and perform resident observations two times concerns, the concern form and follow up fresolution on all fly normal. Additionally checked all fly lights installed new fly stire effective because on Resident#2. On 6/28/18, room in in one room. Mainter flies and a fly swatter in the room per their the halls was composfilies on 6/28/18.	residing on the 700 hall have affected. On 6/20/18, the or noticed a fly in two resident assador Rounds. He went to and returned to the rooms. The Ambassador Program is the customer satisfaction and bough biweekly contact with staff. Responsibilities of the electroactively to residents to and answer questions two are frequently if needed are advocates for our residents and the visits as well as room and the period of the electroactively in the electroactive in	FS	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345155	B. WING _			1	C 06/2018	
NAME OF PROVIDER OR SUPPLIER RANDOLPH HEALTH AND REHABILITATION CENTER				230 E	ET ADDRESS, CITY, STATE, ZIP CODE AST PRESNELL STREET EBORO, NC 27203	,		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 925	window screens were 7/3/18, Pest control a facility assessment. called and requested for assessment with bait provided on 7/6/	tegrity, and quality. Three e repaired on 7/2/18. On arrived and performed a On 7/5/18, Pest Control was to come back to the facility treatment of pesticides and 18.	F	925				
	compliance with the decompliance with the decompliance with the decompliance of the conducted by Assistate Development Coordinators, Social Coordinators, Busines Admissions Coordinators, Transcription of the Coordinators of th	ring the Ambassador Rounds ant Director of Nursing, Staff nators, Minimum Data Set Workers, Medical Records as Office Director, ator, Maintenance Director, ansportation Director, Scheduler, the staff will observations for flies twice in resident care areas. If noted, the Ambassador will as appropriate, notify the omplete a work order. The checked and changed by actor as needed twice intenance Director will						
	summer months to dineeds to be changed Maintenance Directo will accompany Pest	etermine if fly sticky paper						

I ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED		
		345155	B. WING		C 07/06/2018		
NAME OF PROVIDER OR SUPPLIER RANDOLPH HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203				
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 925	rendered. Beginning 7/5/18 al the Staff Developm Supervisor, 11-7 Ni Coordinators, Unit I of Nursing, Dietary Housekeeping Man staff they are not to Hall door, complete screens and to atte Charge Nurse and maggots or pests a Results of the audit Nursing Home Adm Quality Assurance almprovement Comrof three months to interventions and re Assurance and Per Committee to as	Il staff education provided by ent Coordinator, 3- 11 Nurse urse Supervisor, Unit Managers, Assistant Director Manager, Rehab Manager, ager was initiated to educate enter or exit through the 700 e a work order for torn window mpt to eradicate, notify the complete a work order if flies, re noted. Is will be presented by the sinistrator for review in the eand Performance mittee monthly for a minimum validate success of the ecommendations of Quality formance Improvement re compliance is sustained	F 92	5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
345155 B. WING _			C 				
NAME OF PROVIDER OR SUPPLIER RANDOLPH HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, Z 230 EAST PRESNELL STREET ASHEBORO, NC 27203		07700/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE	
F 925	and maintaining a cle completed for 123 sta 56 staff members on professional pest con the facility grounds w	an facility in-service was aff members on 7/2/18 and 7/3/18. On 7/6/18 outside trol was observed to treat ith a liquid spray. On 7/6/18 ed that the facility and	FS	925			