PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ` ′		(X3) DATE SURVEY COMPLETED		
	345184	B. WING _				C /03/2018
	E & REHAB-ELIZABETH CITY		901 SC	OUTH HALSTEAD BOULEVARD	, 33.	30.20.10
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	(	(EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION DATE
§483.10(j) Grievances §483.10(j)(1) The res grievances to the faci that hears grievances reprisal and without for reprisal. Such grievances respect to care and tr furnished as well as the furnished, the behavior residents, and other of facility stay.  §483.10(j)(2) The rest facility must make processore grievances the accordance with this factor facility must make processore grievances the accordance with this factor facility files and the resident.  §483.10(j)(3) The factor factor facility files and the resident.  §483.10(j)(4) The factor factor facility files factor f	ident has the right to voice lity or other agency or entity without discrimination or ear of discrimination and the eatment which has not been or of staff and of other concerns regarding their LTC dident has the right to and the eatment earlier to an earlier to a concerns regarding their LTC dident has the right to and the eather earlier to an earlier to a concerns regarding their LTC dident has the right to and the earlier earlier to an e	F	585			8/29/18
·	<u> </u>			TITI F		(X6) DATE
	GRECTION  ROVIDER OR SUPPLIER  SUMMARY ST. (EACH DEFICIENC' REGULATORY OR I.  Grievances CFR(s): 483.10(j)(1)-0  §483.10(j) Grievances §483.10(j)(1) The res grievances to the faci that hears grievances reprisal and without for reprisal. Such grievar respect to care and tr furnished as well as th furnished, the behavior residents, and other of facility stay.  §483.10(j)(2) The res facility must make pro resolve grievances th accordance with this  §483.10(j)(3) The fact on how to file a grieva to the resident.  §483.10(j)(4) The fact grievance policy to er of all grievances rega contained in this para provider must give a to the resident. The g include: (i) Notifying resident i postings in prominent facility of the right to f (meaning spoken) or grievances anonymou of the grievance offici can be filed, that is, h address (mailing and number; a reasonable	A SOVIDER OR SUPPLIER  DIA TRANSITIONAL CARE & REHAB-ELIZABETH CITY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Grievances  CFR(s): 483.10(j)(1)-(4)  §483.10(j) Grievances. §483.10(j) (1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.  §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.  §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.  §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:  (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for	A BUILDIN 345184  B. WING	A BUILDING  345184  ROVIDER OR SUPPLIER  DIA TRANSITIONAL CARE & REHAB-ELIZABETH CITY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Grievances  CFR(s): 483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.  \$483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.  \$483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.  \$483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:  (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for	SABULDING   SABU	A BUILDING

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

08/24/2018

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.

**Electronically Signed** 

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345184	B. WING _				C 03/2018	
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAI	RE & REHAB-ELIZABETH CITY		90	REET ADDRESS, CITY, STATE, ZIP CODE  1 SOUTH HALSTEAD BOULEVARD  LIZABETH CITY, NC 27909	1 00/	00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 585	to obtain a written de grievance; and the coundependent entities be filed, that is, the public quality Improvement Agency and State Lourogram or protection (ii) Identifying a Grievance responsible for oversure receiving and tracking conclusions; leading by the facility; maintainformation associate example, the identity grievances submitted written grievance decoordinating with stanecessary in light of (iii) As necessary, tal prevent further potentight while the allege investigated; (iv) Consistent with § reporting all alleged vabuse, including injurand/or misappropriate anyone furnishing seprovider, to the admit as required by State (v) Ensuring that all valued the date the grievance of the pertiregarding the resider as to whether the grievance;	or of the grievance; the right cision regarding his or her contact information of with whom grievances may ertinent State agency, Organization, State Survey ing-Term Care Ombudsman in and advocacy system; vance Official who is eeing the grievance process, gigrievances through to their any necessary investigations sining the confidentiality of all ed with grievances, for of the resident for those of anonymously, issuing cisions to the resident; and the and federal agencies as especific allegations; king immediate action to tial violations of any resident diviolation is being  483.12(c)(1), immediately violations involving neglect, ries of unknown source, ion of resident property, by rivices on behalf of the nistrator of the provider; and	F	585				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345184	B. WING		C 08/03/2018
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/03/2010
				901 SOUTH HALSTEAD BOULEVARD	
CONCOR	DIA TRANSITIONAL CAR	RE & REHAB-ELIZABETH CITY		ELIZABETH CITY, NC 27909	
(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 SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 585	and the date the writt (vi) Taking appropriat accordance with Stat of the residents' right or if an outside entity the State Survey Age	s a result of the grievance, en decision was issued;	F 5	35	
	confirms a violation for rights within its area of (vii) Maintaining evided result of all grievance 3 years from the issurdecision.  This REQUIREMENT by:  Based on record revinterviews and staff in issue a written decision the facility to resolve	or any of these residents' of responsibility; and ence demonstrating the es for a period of no less than ence of the grievance  is not met as evidenced ew, policy review, resident enterviews the facility failed to on regarding action taken by grievances for 2 of 2 or grievances. (Resident		Resident #138 is no longer in the facility. Resident #17 grievance was written, completed, and the resident given a copy of the grievance resolu     The Director of Nursing, Staff Development Coordinator, the Executive Director, and or Department Manager	was tion.
	Review of the facility' titled, Complaints/Gri "Procedure: #7. Compromptly acknowledg complainant apprised resolution. #10. The further grievance dec summary of the perting regarding the resident as to whether the grieconfirmed, F., Any cotaken by the facility as	s undated grievance policy, evances, read in part, under aplaints/grievances are ed, investigated, and the disciplination of progress toward a facility ensures that all disciplinations includes, in part: D. A ment findings or conclusions t's concerns, E. A statement evance was confirmed or not prective action taken or to be so a result of the grievance written decision was issued."		performed a one-time 8/23/2018 aud with current resident population to e that any concerns have been proper documented, resolved, and resolution given to resident and/or resident representative according to the grieve policy.  3. The Staff Development Coordinate Executive Director and/or Department Manager re-educated all staff 8/23/2 to the center's policy and procedures regarding the resident right to voice grievances to the facility and the fact responsibility to make prompt efforts	dit nsure rly on vance  or, nt 2018 s

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345184	B. WING				C 03/2018	
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2016	
TO THE OT THE	TO VIDENCO IN COST I EIEN				01 SOUTH HALSTEAD BOULEVARD			
CONCOR	DIA TRANSITIONAL CA	RE & REHAB-ELIZABETH CITY			LIZABETH CITY, NC 27909			
	0.1141415140	TATELLEN TO SECULIA SE		_	<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT 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 585	Continued From pag	ge 3	F !	585				
	1. Resident #138 w	as originally admitted to the			resolve grievances. Staff not available	for		
		ith diagnoses including			re-education by set date will be educat			
	_	nic Obstructive Pulmonary			before next working shift.			
		lation, Type 2 Diabetes						
	Mellitus, Cognitive C	Communication Deficit and			4. The Director of Nursing, Staff			
	Alzheimer's Disease	e. According to the most			Development Coordinator, Executive			
	recent Discharge Mi	nimum Data Set (MDS) dated			Director and/or Department Manager w	/ill		
	2/15/18 revealed Re	sident #138 was cognitively			audit 5 residents 2 times a week for 4			
		ed extensive supervision in			weeks and audit 5 residents once a we			
	most areas of activit	ies of daily living.			for 4 weeks, then monthly for 3 months			
					ensure all resident concerns have beer			
		eport dated 2/10/18, read in			documented and resolved according to			
		amily patient pulled out his			the grievance policy.			
		was not in his right mind due			5 Data recults will be reviewed and			
		this was attributed to his			5. Data results will be reviewed and			
		placed on 2/6/18 in addition to e past 3 days. We will admit			analyzed at the center's monthly Qualit Assurance and Performance	у		
	-	chronic systolic exacerbation.			Improvement meeting for three months			
		orkup is warranted at this			with a subsequent Plan of Correction a			
	time."	omap to warrantou at the			needed.			
	Reviewed of hospita	Il discharge medication orders						
		n part, "Exelon 9.5 mg./24 hr.						
		o affected area once a day.						
	Generic: Rivastigmin	ne." Resident #138 was						
	readmitted to the ho	spital again on 2/10/18, when						
		e exelon patch was last						
	•	and other patches were not						
	placed for three day	S.						
	During an interview	on 8/1/18 at 1:00 PM, the						
		DON) revealed Resident						
		d to the hospital from 2/2/18						
		revealed when he was						
	readmitted back to t	he facility on 2/6/18, he had a						
		patch which was supposed to						
	be applied, removed	and replaced every 24 hrs.						
		dent #138 was discharged to						
	the hospital again or	n 2/10/18 and an Exelon						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		345184	B. WING _			08/0	; 03/2018
	ROVIDER OR SUPPLIER	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE 901 SOUTH HALSTEAD BOUL ELIZABETH CITY, NC 2790	EVARD	00/0	0.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIA' ICIENCY)		(X5) COMPLETION DATE
F 585	patch dated 2/6/18 h replaced. The DON rorders from the hosp stated she did not kn removed and replace that a meeting was h family member on 2/ and filed a grievance remove and replace stated she did inserv She revealed a griev Resident #138's fam sign or get a copy of During another intervithe Director of Nursin not aware she was s decision to the reside regarding resolution During an interview of Administrator revealed for staff to follow-up of the written deresident/resident represolution of the grievalue of	ad not been removed and revealed the discharge sital were not followed. She low why the patch was not ed daily. The DON explained seld with Resident #138's 16/18 who voiced concerns about the facility's failure to the Exelon patch. The DON ices and audits on patches. Fance was completed but sily member never returned to the written grievance.  Ariew on 8/3/18 at 10:50 AM, and (DON) revealed she was supposed to send a written ent/resident representative of the grievance.  And (BON) revealed she was upposed to send a written ent/resident representative of the grievance.  And (BON) revealed she was upposed to send a written ent/resident representative regarding wance.  And (BON) revealed she was upposed to send a written ent/resident representative regarding wance.	F	585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345184	B. WING _			C 9/03/3049	
	ROVIDER OR SUPPLIER	CARE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CO 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909		8/03/2018	
(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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 585	July 2018 revealed grievances filed by On 7/31/2018 at 1 conducted with Restated on 7/18/20 have someone moway so she could bathroom. A 3:00 assistant (NA), cathe call light and anything for herse was annoyed by the chair for herogrievance about the Nursing (DON) on stated she had no outcome from any On 8/1/2018 at 4:2 conducted with Nursing tight and resident could nurse stated she comoving the chair.  On 8/1/2018 at 4:2 conducted with the who stated she had about the NA on 7 a grievance form the rin person. The was settled becaute would handle it as	d no documentation of y Resident #17.  2:15 PM, an interview was esident #17. The Resident 18, she put her call light on to ove a stationary chair out of the maneuver her wheelchair to the PM to 11:00 PM nursing me to her room and turned off isked her if she couldn't do olf. The Resident stated she his statement and put her call d a nurse came in and moved The resident stated she filed a ne NA with the Director of 17/23/2018. The resident the ard anything about the	F	585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345184	B. WING _			C / <b>03/2018</b>		
	ROVIDER OR SUPPLIER	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	•	03/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 625 SS=C	CFR(s): 483.15(d)(1) §483.15(d) Notice of §483.15(d)(1) Notice nursing facility transi the resident goes on nursing facility must the resident or reside specifies- (i) The duration of th any, during which the return and resume re facility; (ii) The reserve bed plan, under § 447.40 (iii) The nursing facil bed-hold periods, wh paragraph (e)(1) of t resident to return; ar (iv) The information of this section.  §483.15(d)(2) Bed-h the time of transfer of hospitalization or the facility must provide resident representat specifies the duration described in paragra This REQUIREMEN by: Based on record rev interviews the facility	bed-hold policy and returnation to be before transfer. Before a fers a resident to a hospital or therapeutic leave, the provide written information to be ent representative that  e state bed-hold policy, if the resident is permitted to be besidence in the nursing the payment policy in the state of this chapter, if any; ity's policies regarding hich must be consistent with this section, permitting a hid be specified in paragraph (e)(1)  cold notice upon transfer. At the far resident for the resident and the live written notice which in of the bed-hold policy aph (d)(1) of this section.  T is not met as evidenced to residents upon discharge ident #70).	F 6	1. Resident #70 has received hold policy 8/09/2018.  2. The Director of Nursing, and Staff Development Coordinate a one-time audit 8/17/2018 will resident population to validate	d or the or performed th current	8/29/18		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345184	B. WING				C	
NAME OF D	DOVIDED OD CURRUER	343104	B. WING_	CTI	DEET ADDRESS CITY STATE ZID CODE	08/	03/2018	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
CONCOR	DIA TRANSITIONAL CA	ARE & REHAB-ELIZABETH CITY			1 SOUTH HALSTEAD BOULEVARD			
				EL	LIZABETH CITY, NC 27909			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY 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 625	Continued From pag	ge 7	F 6	625				
	Review of the facility	y's Bed-Hold & Readmission			resident received the bed hold policy u	pon		
		17, read in part, "Policy: The			transfer to a hospital or the resident go			
		ven to the resident and			on therapeutic leave.			
		tive at admission, when any			·			
	changes occur unde	er the state plan, and at time			3. The Staff Development Coordinator			
		ıtic leave or temporary			re-educate Licensed Nurses 8/15/2018	to to		
	_	an emergency transfer is			the center's policy and procedures in			
		is provided to the resident,			regards to providing the resident and			
		esentative upon transfer. The			resident representative written notice			
	-	be included in the papers sent			which specifies the duration of the bed hold policy. Staff not available for training			
			by set date will be educated before nex	•				
		working shift.						
		gnoses including Obstructive						
		pe 2 diabetes mellitus.			4. The Director of Nursing, Staff			
		est recent Admission Minimum			Development Coordinator and or			
	Data Set (MDS) date	ed 7/18/18, Resident #70 was			Administrative Nurse will audit transfer	red		
		and required extensive			residents 2 times a week for 4 weeks,			
	-	areas of activities of daily			then weekly for 4 weeks and monthly for			
	living.				months to ensure each resident receive	ed		
	Davison of a monacle	t. detect 0/4/40 et 4:44			the bed hold policy upon transfer to a			
		note dated 8/1/18 at 4:44			hospital or the resident goes on			
		/30/18, 3:10 PM, Resident ncy room this shift for lethargy			therapeutic leave.			
		ention per medical doctor."			5. Data results will be reviewed and			
	ara abaorimiai aioto	men per medicar decier.			analyzed at the center's monthly Qualit	tv		
	During an interview	on 8/2/18 at 1:26 PM, Staff			Assurance and Performance	.,		
	_	n preparation to send			Improvement meeting for three months	;		
	Resident				with a subsequent Plan of Correction a	ı <b>S</b>		
	#70 to the hospital s	she sent a copy of his orders,			needed.			
		tration Record (MAR), Face						
		story and physical. She stated						
		as not included in the						
	information sent to t	he hospital with the resident.						
	During an interview	on 8/2/18 at 3:11 PM, the						
		(DON) revealed when						
	_	narged to the hospital, the						
		nager and the Admission						

PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245404	B. WING			1	С
		345184	B. WING			08/	03/2018
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAR	E & REHAB-ELIZABETH CITY		90	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HALSTEAD BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 625	She said during morn about bed holds and stated residents signed admission to the hosp.  During an interview of Administrator revealed the bed hold policy has with the resident upon She revealed her expression would be that the bed the resident to the hold baseline Care Plan	andled the bed hold policy.  ing meetings they talked contacting the family. She ed the bed hold policy on bital.  In 8/3/18 at 11:16 PM, the d she was not aware that ad to be sent to the hospital in discharge to the hospital.  Dectation going forward I hold policy will be sent with spital.		625 655			8/29/18
SS=D	Planning §483.21(a) Baseline (§483.21(a)(1) The fac- implement a baseline that includes the instressional that includes the instressional that meet professional the baseline care place (i) Be developed with admission.  (ii) Include the minimum necessary to properly including, but not limit (A) Initial goals based (B) Physician orders.  (C) Dietary orders.  (D) Therapy services.  (E) Social services.	Care Plans cility must develop and care plan for each resident ructions needed to provide centered care of the resident al standards of quality care. In must- in 48 hours of a resident's  rum healthcare information or care for a resident ted to- d on admission orders.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345184	B. WING _			1	03/2018
	ROVIDER OR SUPPLIER	RE & REHAB-ELIZABETH CITY	•	90	TREET ADDRESS, CITY, STATE, ZIP CODE  11 SOUTH HALSTEAD BOULEVARD  LIZABETH CITY, NC 27909	, 50.	30.20.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	care plan if the com (i) Is developed with admission. (ii) Meets the require (b) of this section (e this section).  §483.21(a)(3) The firesident and their re of the baseline care limited to: (i) The initial goals of (ii) A summary of th dietary instructions. (iii) Any services an administered by the on behalf of the faci (iv) Any updated info of the comprehensiv. This REQUIREMEN by: Based on record re facility failed to prov summary baseline of residents (Resident representative.  The findings include  Resident #70 was o on 7/11/18, with diag sleep apnea and Ty According to the mo	e plan in place of the baseline orehensive care plannin 48 hours of the resident's ements set forth in paragraph excepting paragraph (b)(2)(i) of accility must provide the presentative with a summary plan that includes but is not of the resident. The resident is medications and defeatility and personnel acting ity. The provided on the details recare plan, as necessary. The is not met as evidenced wiew and staff interviews the ide evidence that a written are plan was given to 1 of 1 #70) and/or resident's	F	355	<ol> <li>Resident #70's baseline care plan verviewed on 8/09/2018 with the resident representative, signed copy placed in resident's chart.</li> <li>The Director of Nursing and or Staff Development Coordinator performed at one-time audit 8/24/2018 with current resident population for all residents admitted in the last 21 days to validate that the baseline care plan has been reviewed with the resident and/or resident's representative.</li> </ol>	nt's	
	cognitively impaired	and required extensive areas of activities of daily			3. The Director of Nursing and/or Staff Development Coordinator re-educated Licensed Nursing and Interdisciplinary		

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345184	B. WING _			1	03/2018
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010
				90	01 SOUTH HALSTEAD BOULEVARD		
CONCOR	DIA TRANSITIONAL CAR	RE & REHAB-ELIZABETH CITY			LIZABETH CITY, NC 27909		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From page	e 10	F 6	655			
	plan revealed the car	70's undated baseline care e plan was not signed by presentative of Resident #70.			Team 8/24/2018 to review the summar baseline care plan with the resident an resident's representative and place a signed copy in the resident's chart. Sta	d/or	
	_				not available for training by set date wi educated before next working shift. All new admissions will be reviewed in clir morning meeting to ensure baseline ca	nical	
		ed the Director of Nursing			plan summary is reviewed with the resident and/or resident representative		
	Corporate Nurse reve signed copy of the ba	n 8/3/18 at 9:30 AM, the ealed he could provide a seline care plan by the nave it signed by Resident family member.			4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit all new admissions 3 times weekly for one monthen weekly for one month, and then monthly for one month to ensure basel		
	Director of Nursing (Director of Nurse or nurse management)	n 8/3/18 at 10:53 AM, the OON) revealed the admitting ger completed the initial			care plan summary is reviewed with the resident and/or resident representative	e	
	said nurse managers	eline care plans and she are now aware that the sentative must sign the			5. Data results will be reviewed and analyzed at the center's monthly Qualit Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction a	;	
	Administrator reveale that baseline care pla resident and/or repres				needed.		
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F 6	656			8/29/18
	implement a compreh care plan for each res	cility must develop and nensive person-centered sident, consistent with the the at §483.10(c)(2) and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245494	B. WING			1	С	
	DOV #DED OF OURDINED	345184	D. WING_	0.7.0		08/	03/2018	
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
CONCOR	DIA TRANSITIONAL C	ARE & REHAB-ELIZABETH CITY			SOUTH HALSTEAD BOULEVARD			
				ELIZ	ZABETH CITY, NC 27909			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI: TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 656	Continued From pa	age 11	F	656				
	objectives and time	eframes to meet a resident's						
	•	and mental and psychosocial						
		ntified in the comprehensive						
		comprehensive care plan must						
	describe the follow							
	(i) The services that	at are to be furnished to attain						
	or maintain the res	ident's highest practicable						
	1	nd psychosocial well-being as						
	required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not							
	•	e resident's exercise of rights						
	_	luding the right to refuse						
	treatment under §4	d services or specialized						
		ces the nursing facility will						
	provide as a result							
	'	If a facility disagrees with the						
		SARR, it must indicate its						
	_	ident's medical record.						
	(iv)In consultation	with the resident and the						
	resident's represer	ntative(s)-						
	(A) The resident's	goals for admission and						
	desired outcomes.							
		preference and potential for						
		acilities must document						
		nt's desire to return to the						
		sessed and any referrals to						
		cies and/or other appropriate						
	entities, for this pur							
		s in the comprehensive care e, in accordance with the						
	•	orth in paragraph (c) of this						
	section.	orum in paragraph (C) Or uns						
		NT is not met as evidenced						
	by:	is not mot as evidenced						
		eview, observations and staff			1. Resident #33's supplement order w	/as		
		lity failed to implement care			corrected and given on 8/02/2018 by	-		
		by not applying a hand splint or			charge nurse, splint, ted hose applied,			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345184	B. WING_				C <b>03/2018</b>	
NAME OF PE	ROVIDER OR SUPPLIER		<del></del>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2016	
TO UNIC OF TH	TO VIDEN OIL OIL TELEN				01 SOUTH HALSTEAD BOULEVARD			
CONCOR	DIA TRANSITIONAL CA	RE & REHAB-ELIZABETH CITY			LIZABETH CITY, NC 27909			
					<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R 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 page	ge 12	F 6	656				
	providing passive ra	nge of motion, not providing			and PROM performed by Certified			
	dietary supplements				Nursing Assistant on 8/02/2018.			
		or 1 of 20 residents reviewed			, and the second			
	for care plans (Resid				2. The Director of Nursing, Staff			
	. ,	,			Development Coordinator, and/or			
	The findings include	d:			Administrative Nurse completed a			
	•				one-time audit 8/17/2018 with current			
	1. Resident #33 was	admitted to the facility on			resident population to validate that			
	3/10/15 with diagnos	ses including Diabetes			residents receiving splints and ted hose	е		
	Mellitus, Chronic Iso	chemic Heart disease,			has an appropriate care plan, physiciar	า		
	Hemiplegia and Her	niparesis following a			order(s) in place, and device applied to	)		
	Cerebrovascular Ac	cident and Dementia.			residents. The Director of Nursing, Sta	ff		
					Development Coordinator, and/or			
		recent quarterly Minimum			Administrative Nurse completed a			
		sessment dated 6/14/18			one-time audit 8/17/2018 with current			
		#33 as moderately cognitively			population to ensure that residents with			
	3	exhibit behaviors. He was an			supplements and PROM to validate ca	re		
	•	n assist with bed mobility and			plan is appropriate.			
	-	uired extensive one person			0. The Ote# Development Occursion at a			
		ng. Resident #33 had both			3. The Staff Development Coordinator	1		
		remity range of motion			and/or Administrative Nurse re-educate	ea		
		ide. He was not receiving			all nursing staff 8/24/2018 to provide			
		Occupational therapy. He ative nursing program or			splint, ted hose, and supplements per physician order and item is care planne	nd		
	receiving splint or br				The Rehabilitation Manager re-educate			
	receiving spirit or bi	ace assistance.			all Certified Nursing Assistants 8/24/20			
	a Review of the Ca	re Area Assessment dated			on PROM. Staff not available for traini			
		d Resident #33 required			by set date will be educated before nex	-		
		ving (ADL) assistance and			working shift. The Director of Nursing a			
	had contractures.	( 1.2.2) addictained and			Interdisciplinary Team will review care			
					plans for any revisions in weekly			
	Review of the Physi	cian's Order dated 4/3/18			Standards of Care meetings to ensure			
	read Resident #33 v				care plans are implemented.			
		py services. The resident			·			
	-	ive range of motion (PROM)			4. The Director of Nursing, Staff			
		elbow, wrist and digits daily			Development Coordinator, and/or			
		on a hand splint with built up digit			Administrative Nurse will audit 5 reside	nts		
	support.				with splints, ted hose, supplements, an	d		
				PROM 3 times a week for 4 weeks, the	en			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345184	B. WING _				C 03/2018
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAF	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909		, 00.	00.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	documented a Focus having an ADL Self-crelated to his Cerebro hemiparesis (left side in meeting the goal of function included at Review of the March assessment documer was at 86 degrees to range of motion.  Review of the August assessment documer was at 72 degrees to range of motion prior documented the residelbow splint.  Observations of Resident was observed with a and there was no visit Observations on 7/31 Resident #33 in his was place in his contracted left of Observations on 8/1/	lan, revision date 5/21/15, area for Resident #33 are performance deficit by ascular Accident with id weakness). Interventions fimproving the current level left-hand splint as ordered.  2018 Occupational Therapy inted Resident #33's elbow 65 degrees with passive  2018 Occupational Therapy inted Resident #33's elbow 62 degrees with passive to pain. The assessment ident was a candidate for ident was a candidate for ident #33 on 7/31/18 at 11:54 wheelchair for lunch. He contracture to the left hand ble hand splint in place.  /18 at 1:35 PM revealed wheelchair with no splint in in d left hand.  /18 at 3:52 PM revealed with no hand splint in place	F	556	once a week for two months to ensure residents care plans are followed.  5. Data results will be reviewed and analyzed at the center's monthly Qualit Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction a needed.	cy s	
		nand. 18 at 11:28 AM revealed bed with no hand splint in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		ISTRUCTION	(X3) DATE SURVEY COMPLETED		
		345184	B. WING _				C 08/03/2018	
NAME OF PF	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2010	
				901 S	OUTH HALSTEAD BOULEVARD			
CONCOR	DIA TRANSITIONAL CAF	RE & REHAB-ELIZABETH CITY		ELIZA	ABETH CITY, NC 27909			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 656	Continued From page	e 14	F 6	656				
	place in his contracte	d left hand.						
		18 at 8:06 AM revealed with no hand splint in place hand.						
	Nursing Assistant (Na with Resident #33, sh wear wrist splits and	on 8/01/18 at 9:08 AM with A #1), who frequently worked the stated the resident did not had never placed hand at. She further stated he hand at all.						
	March 2018 and Aug 8/02/18 at 8:42 AM s always had a hand speed approximately two we passive range of mot splint. She further stasshe informed the numof the splint and how stated there was no reacility and this mean responsible for doing and applying the splint placed the splint in the O.T. and State Agence Resident #33's room splint out of the top do the SA and NA#3, who was to be used. NA # looked at the residen smell skin". She atter and the muscle was resident was to see the second splint out of the second splint out of the top do the SA and NA#3, who was to be used. NA # looked at the residen smell skin". She atter and the muscle was the second splint out of the splint out of the top do the SA and NA#3, who was to be used. NA # looked at the residen smell skin". She atter and the muscle was the second splint out of the splint out of the top do the splint out of the splint out of the top do the splint out of th	with the Occupational had completed both the ust 2018 assessment, on he stated Resident #33 had blint and in March 2018 a d. She stated she worked for eeks with the resident doing ion and using the hand ted at the end of two weeks se and the nursing assistant and when to use it. She estorative program at the t the nursing assistants were the passive range of motion nt. She stated she had the top dresser drawer. The try (SA) walked down to and the O.T. pulled the resser drawer and showed to was in the room, how it did stated, "ok." The O.T. then try left elbow and stated "I mpted to move the left elbow tight. She stated she would most likely place an elbow						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345184	B. WING			C 08/03/2018	
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CA	ARE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	•	33,733,720,10	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	important to do the muscles from gettin had given instruction nursing staff that the splint 4-6 hours per after PROM had be morning care. She haugust 2018 evaluate 8/2/18, the resident his left elbow in a glin March 2018, the resting position or ppassive range of mocontracture and hyperocontracture and hype	She stated it was very PROM exercises to keep the g tight. She then stated she ns in March 2018 to the e resident was to wear the day during the 7am-3pm shift en completed during his further documented on the ation that upon arrival on presented supine in bed with uarded position on his chest. resident did not exhibit this vain after 10 degrees of otion, displaying increase pertonicity (tightness). She sident would benefit from a full lese concerns.  on 8/02/18 at 1:32 PM with leted he had not had a splint on with NA #3 on 8/02/18 at 1:32 did not have the resident on NA #2 had him.  with NA #2 on 8/02/18 at 1:34 had not worked with the lay and had no idea he was to did not state if PROM had	F 6	56			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			E SURVEY IPLETED		
		345184	B. WING _			0.8	C 3/03/2018	
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CA	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909		•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From pag	ge 16	F	656				
	Administration Reco in wrong, so it never	ot get on the Medication rd because the nurse keyed it showed up to be done.						
	Director of Nursing s hand splint was not Medication Administ the Kardex. She stat from the care plan a could see this in poin nursing station, on the hand-held device. S motion should have	on 8/2/17 at 2:48 PM with the she stated the order for the transferred correctly to the ration Record but it was on ted the Kardex was created and the nursing assistants at of care, either at the ne wall station or their he stated passive range of been completed during the and splint should have been in						
	8/3/18 at 10:40 AM s	with the Administrator on she stated the hand splint n and the care plan followed.						
	10/18/16 documente	vsician's Order dated ed an order for a Glucose pplement one container three M, 12PM and 4PM.						
	(MAR) for 2/2018 the order for a Glucose	tainer three times a day and						
	documented a focus at a nutritional risk re	Plan, revised on 10/11/17, area for Resident #33 being elated to skin integrity. n meeting the goal of no ange included						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345184	B. WING _			1	C 03/2018		
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	00/2010		
CONCOR	DIA TRANSITIONAL CAF	RE & REHAB-ELIZABETH CITY		9	901 SOUTH HALSTEAD BOULEVARD				
	5# ( 110 til ( 011			E	ELIZABETH CITY, NC 27909				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE		
F 656	Continued From page	e 17	F 6	356	8				
	diet/supplement as o	rdered.							
	his recorded weight of This reflects an 8.9%  Observations on 8/1/ any supplement on the meal tray.	8 weight of 220 pounds and on 8/2/18 was 200.5 pounds. weight loss in six months.  18 at 8:49 AM did not reveal ne resident's bedside table or							
		18 at 1:03 PM of lunch did ement on the resident's all tray.							
	9:07 AM she stated to Glucose Control support she did not know	vith Nurse #1 on 8/1/18 at he resident received a plement three times daily, who was responsible for dent and stated it must come							
	1 on 8/1/18 at 9:10 A	vith Nursing Assistant (NA) # M she stated the resident ement on his meal tray and e gave that to him.							
	8/02/18 at 9:22 AM s	vith the Dietary Manager on he stated dietary was not ements on the meal trays I supplements.							
	on 8/2/18 at 9:49 AM	vith the Registered Dietician she stated Resident #33 oplements with med pass.							
	_	vith the Director of Nursing M she stated all supplements ses and are on the							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345184	B. WING _			C <b>08/03/2018</b>	
	ROVIDER OR SUPPLIER	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CO 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909		00/03/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	medication cart. The the supplements and supplement isn't give it as given.  During a follow up in 8/02/18 at 10:15 AM documented the Glu given on the MAR be supplements come to tray and she assume supplements. She stoday that nurses are the supplements. She stoday that nurses are the supplements. She stoday that nurses are the supplements. She Glucose control from facility did not have to ordered.  During a follow up in Dietician on 8/02/18 about six months agon the glucose control shad been ordered. Swhy this was not add stated the resident programments glucose control nutrification of the material supplements about 6 changed on the MAR resident had receiver 8/3/18 at 10:40 AM states.	terview with Nurse #1 on she stated that she cause typically the hrough dietary on the meal ed he received the tated she was informed e responsible for providing the stated she went to get to the supply room and the he type of supplement  terview with the Registered at 10:35 AM she stated that to the facility stopped carrying supplement that Resident #33 the stated she did not know dressed on any notes and robably had not received the tional supplement since the	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345184	B. WING _			C 08/03/2018	
	ROVIDER OR SUPPLIER	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP COD 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909		30/00/2010	
(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 COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	documented a Focu impaired circulation extremities related to interventions in place free from signs/symedema through the anti-embolism stock.  Review of the Physis revealed an order for knee high stockings removed QHS (ever Edema.  Review of the Treatr (TAR) for 2/2018 through stockings.  Observations on 7/3 #33 was sitting up in table for lunch. His swollen. He was no anti-embolism stock.  During an observation Resident #33 was sitting an observation of the product	re Plan, revised on 3/27/18, s area of resident having and/or edema to the lower of Diabetes and diet. The eto meet the goal of being otoms of the complications of next review date included ings as ordered.  Cian's Order dated 2/8/16 or anti-embolism stockings - Apply in AM (morning) and hing) one time a day for  ment Administration Record ough 8/2018 documented the as being applied daily.  1/18 at 11:42 AM Resident of his wheelchair at his bedside ankles were observed to be twearing ings.  on on 7/31/18 at 1:35 PM titing in his wheelchair. His obe swollen. He was not	F6	S56			
	Resident #33 was ir wearing anti-embolis	-					
	#1 she lifted the bed	on 8/1/17 at 2:28 PM with NA sheets to observe Resident re were no anti-embolism on his legs.					

· · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345184	B. WING		C 08/03/2018		
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAR	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 656	#1 on 8/1/18 at 2:28 never been told the re	vith Nursing Assistant (NA) PM she stated she had	F 65	6			
	have any swelling in his chair.  During an interview of Director of Nursing states stockings should have	n 8/2/17 at 2:48pm the ated the anti-embolism e been on the resident.					
F 657 SS=D	8/3/18 at 10:40 AM s	he stated the anti-embolism e been on Resident #33 as d Revision	F 65	7	8/29/18		
	be- (i) Developed within a the comprehensive a (ii) Prepared by an in includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practite resident and the in An explanation must medical record if the	orehensive care plan must  7 days after completion of ssessment. terdisciplinary team, that nited toysician. e with responsibility for the responsibility for the d and nutrition services staff. eticable, the participation of resident's representative(s). be included in a resident participation of the resident participation of the resident presentative is determined					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345184	B. WING_	B. WING		C 08/03/2018			
NAME OF P	ROVIDER OR SUPPLIER		1		REET ADDRESS, CITY, STATE, ZIP CODE	1 00	0/03/2016		
					1 SOUTH HALSTEAD BOULEVARD				
CONCOR	DIA TRANSITIONAL CA	RE & REHAB-ELIZABETH CITY			LIZABETH CITY, NC 27909				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI  REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 657	disciplines as deterr or as requested by to (iii)Reviewed and reteam after each ass comprehensive and assessments. This REQUIREMEN by: Based on record refacility failed to revisive residents reviewed to (Resident #50).  The findings include Resident #50 was on 3/29/17, with diagram Weakness (General Hypertension and Diphase. According to Minimum Data Set (#50 was cognitively extensive assistance daily living, including Review of a Dieticia dated 6/29/18, read therapy review completails. Summary of by mouth greater the verbal prompts during tolerated. Continue of the second sec	e staff or professionals in mined by the resident's needs he resident. vised by the interdisciplinary essment, including both the quarterly review  IT is not met as evidenced view and staff interviews the ea Care Plan for 1 of 1 for significant weight loss.  d:  riginally admitted to the facility gnoses including Muscle ized), Alzheimer's Disease, ysphagia Oropharyngeal the most recent Quarterly MDS) dated 7/4/18, Resident impaired and required en in most areas of activities of greating.  n's Nutrition Assessment in part, "Medical Nutrition pleted. See assessment for review: Weight stable. Intake an 50%. Does best with ng meals. Current diet being with Plan of Care. Do not	F	657	1. Resident #50 care plan was revise 8/17/2018 to reflect resident's current weight loss and intervention by Minim Data Set Nurse (MDS).  2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 with current resident population to ensure care pla have been updated appropriately.  3. The Staff Development Coordinator and/or Administrative Nurse re-educat Licensed Nurses 8/24/2018 on care prevision for weight change. Staff not available for training by set date will be educated before next working shift. The Director of Nursing and Interdisciplina Team will review weight changes in clinical morning meeting and will be reviewed weekly in Standards of Care meeting to validate compliance.	ns te lan e ne ry			
	not address that Re- recent weight loss fr	n." The RD's Assessment did sident #50 had experienced a rom April 2018 to May 2018.  y Dietician's progress note			<ol> <li>The Director of Nursing and/or Administrative Nurse will audit all residents with weight changes weekly 3 months to ensure care plans are rev regarding any weight changes.</li> </ol>				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		OATE SURVEY OMPLETED
		345184	B. WING _			C 08/03/2018
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CA	ARE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP COI 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909		39.39.2019
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 657	was 152.4 pounds. 2018 of unknown et stable for past three mass index was 27. overweight as her ic pounds. The resider 76-100% with total of staff. Speech Languapropriate food te mechanical soft text should continue to progress note did not had experienced and between April 2018.  Review of Resident 7/12/18, which contishe had a nutritional varied. She had a given change with intake to 75%. The intervention times three weeks, weeks. Diet suppler weights, intake by not revealed the following weight loss 1/3/18 163 2/12/18 165 3/10/18 164 3/14/18 163 4/10/18 165	aled Resident #50's weight She had a weight loss in April, iology. Weight has been months. Resident #50's body 9 and the resident was deal body weight was 110 nt's intake by mouth was dependence on feeding per lage Pathologist evaluation exture being given. Regular ture, Ensure three times daily provide for needs. The RD's ot address that Resident #50 recent weight loss specifically and May 2018.  #50's Care Plan dated inued from 7/12/17 revealed all risk as her intake by mouth oal for no significant weight by mouth no greater than ons included daily weights then weekly weights times 4 ments as ordered. Monitor mouth and labs as available.  #50's weights for a six month resident had experienced the	F6	5. Data results will be review analyzed at the center's more Assurance and Performance Improvement meeting for the with a subsequent Plan of Coneeded.	nthly Quality e ree months	

F 657  Continued From page 23  F 657  During an interview on 8/2/18 at 1:30 PM, the facility Dictician stated she knew Resident #50 lost weight and she said she must have missed it by not updating the resident's care plan to address the weight loss. She revealed Resident #50 had been fine for several years and the speech therapist had evaluated her for texture. She stated they were concerned about her weight loss and she didn't know why she did not document it. She revealed she did not know about updating the care plan when a resident experienced weight changes.  During an interview on 8/2/18 at 1:52 PM, the MDS Coordinator revealed the last time Resident #50°s Care Plan was updated was 7/12/18. She stated if Resident #50 had weight loss, the Dictician would look at any weight changes and would make a note if there was a weight change.  During an interview on 8/2/18 at 3:17 PM, the Director of Nursing (DON) revealed Resident #50 gained a lot of weight when she was initially admitted to the facility and she gained a few pounds here and there. She stated it would be up to the Dictician to make a note about Resident #50's weight loss. She stated it would have benefited her to lose weight because her rhyroid level was abnormal. She revealed the Dietician should have addressed the weight loss at the time of the weight loss and even if was a good thing for Resident #50 to lose weight, the Dietician should have documented it. The DON further stated she would have expected the	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
STREET ADDRESS. CITY, STATE. JIP CODE			345184	B. WING _			1			
CONCORDIA TRANSITIONAL CARE & REHAB-ELIZABETH CITY   C 27909	NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE				
CALL   DECEMBER   CHY, No. 27868   DECEMBER   DECEMBE	CONCOR	DIA TRANSITIONAL CAE	RE & REHAR-ELIZARETH CITY		90	01 SOUTH HALSTEAD BOULEVARD				
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 657  Continued From page 23  During an interview on 8/2/18 at 1:30 PM, the facility Dietician stated she knew Resident #50 lost weight and she said she must have missed it by not updating the residents care plan to address the weight loss. She revealed Resident #50 had been fine for several years and the speech therapist had evaluated her for fexture. She stated they were concerned about her weight loss and she didn't know why she did not document it. She revealed she did not know about updating the care plan when a resident experienced weight changes.  During an interview on 8/2/18 at 1:52 PM, the MDS Coordinator revealed the last time Resident #50°s Care Plan was updated was 7/12/18. She stated if Resident #50 had weight loss, the Dietician would look at any weight changes and would make a note if there was a weight change.  During an interview on 8/2/18 at 3:17 PM, the Director of Nursing (DON) revealed Resident #50 gained a lot of weight when she was initially admitted to the facility and she gained a few pounds here and there. She stated it would have benefited her to lose weight because her thyroid level was abnormal. She revealed the Dietician should have addressed the weight loss at the time of the weight loss and even if it was a good thing for Resident #50 to lose weight, the Dietician should have documented it. The DON further stated she would have expected the	CONCOR	DIA TRANSITIONAL CAI	CE & REHAD-ELIZABETH OH I		Е	LIZABETH CITY, NC 27909				
During an interview on 8/2/18 at 1:30 PM, the facility Dietician stated she knew Resident #50 lost weight and she said she must have missed it by not updating the resident's care plan to address the weight loss. She revealed Resident #50 had been fine for several years and the speech therapist had evaluated her for texture. She stated they were concerned about her weight loss and she didn't know why she did not document it. She revealed she did not know about updating the care plan when a resident experienced weight changes.  During an interview on 8/2/18 at 1:52 PM, the MDS Coordinator revealed the last time Resident #50's Care Plan was updated was 7/12/18. She stated if Resident #50 had weight loss, the Dietician would look at any weight changes and would make a note if there was a weight change.  During an interview on 8/2/18 at 3:17 PM, the Director of Nursing (DON) revealed Resident #50 gained a lot of weight when she was initially admitted to the facility and she gained a few pounds here and there. She stated it would be up to the Dietician to make a note about Resident #50's weight loss. She stated it would have benefited her to lose weight because her thyroid level was abnormal. She revealed the Dietician should have addressed the weight loss at the time of the weight loss and even if it was a good thing for Resident #50 to lose weight, the Dietician should have documented it. The DON further stated she would have dexpected the	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI	х	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION		
facility Dietician stated she knew Resident #50 lost weight and she said she must have missed it by not updating the resident's care plan to address the weight loss. She revealed Resident #50 had been fine for several years and the speech therapist had evaluated her for texture. She stated they were concerned about her weight loss and she didn't know why she did not document it. She revealed she did not know about updating the care plan when a resident experienced weight changes.  During an interview on 8/2/18 at 1:52 PM, the MDS Coordinator revealed the last time Resident #50's Care Plan was updated was 7/12/18. She stated if Resident #50 had weight loss, the Dietician would look at any weight changes and would make a note if there was a weight change.  During an interview on 8/2/18 at 3:17 PM, the Director of Nursing (DON) revealed Resident #50 gained a lot of weight when she was initially admitted to the facility and she gained a few pounds here and there. She stated it would be up to the Dietician to make a note about Resident #50's weight loss. She stated it would have benefited her to lose weight because her thyroid level was abnormal. She revealed the Dietician should have addressed the weight loss at the time of the weight loss and even if it was a good thing for Resident #50 to lose weight, the Dietician should have documented it. The DON further stated she would have expected the	F 657	Continued From pag	e 23	F	657					
Dietician to update Resident #50's Care Plan.  During an interview on 8/3/18 at 11:22 AM the  Administrator revealed her expectation would be		facility Dietician state lost weight and she so by not updating the maddress the weight of #50 had been fine for speech therapist had She stated they were loss and she didn't kild document it. She revalout updating the carperienced weight of MDS Coordinator reversions Care Plan was stated if Resident #50 Dietician would look would make a note if During an interview of Director of Nursing (I gained a lot of weigh admitted to the facilit pounds here and the to the Dietician to mathematical was abnormal should have address time of the weight loss thing for Resident #50 Dietician should have further stated she would buring an interview of Director to update R	ed she knew Resident #50 said she must have missed it esident's care plan to loss. She revealed Resident in several years and the devaluated her for texture. It concerned about her weight how why she did not wealed she did not know are plan when a resident changes.  In 8/2/18 at 1:52 PM, the wealed the last time Resident updated was 7/12/18. She in the weight loss, the last any weight changes and there was a weight change.  In 8/2/18 at 3:17 PM, the loon) revealed Resident #50 to when she was initially yeard she gained a few re. She stated it would be upake a note about Resident weight because her thyroid She revealed the Dietician led the weight loss at the loss and even if it was a good of to lose weight, the edocumented it. The DON build have expected the lesident #50's Care Plan.							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE COMF	SURVEY
		345184	B. WING _				C / <b>03/2018</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	,	00.2010
CONCOR	DIA TRANSITIONAL CAR	RE & REHAB-ELIZABETH CITY			1 SOUTH HALSTEAD BOULEVARD		
				EL	LIZABETH CITY, NC 27909		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	e 24	F 6	657			
	that the Dietician wou Care Plan.	ıld update the resident's					
F 658 SS=D	Services Provided Me CFR(s): 483.21(b)(3)	eet Professional Standards (i)	F 6	658			8/29/18
	as outlined by the comust- (i) Meet professional This REQUIREMENT by: Based on record revifacility failed to order residents who had phurinalysis (Resident # discharge orders from replace Exelon patch reviewed. (Resident# The findings included 1. Resident # 11 was 1/4/13 with diagnoses Renal Disease, Arterional Disease, Arterional Disease, Arterional Disease, Arterional Disease, and Review of the nurse of the resident complain when urinating. The	d or arranged by the facility, mprehensive care plan, standards of quality. T is not met as evidenced liew and staff interviews the a urinalysis for 1 of 1 hysician's orders for a # 11) and failed to follow in the hospital to remove and es for 1 of 1 residents # 138).  It: admitted to the facility on so of Dementia, End Stage iosclerosis and Anxiety.  Minimum Data Set (MDS) ed the resident # 11 required with bed mobility, transfers,			<ol> <li>Resident #138 is no longer in the facility. Resident #11, Medical Doctor discontinued order 8/03/2018 for urinalysis related to absence of symptoms.</li> <li>The Director of Nursing, and or the Staff Development Coordinator perform a one-time audit 8/17/2018 with curren resident population to ensure new physician orders on all residents within last 30 days were followed.</li> <li>The Staff Development Coordinator re-educated all Licensed Nurses 8/24/2018 on following physician order Staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by set dawill be educated before next working staff not available for training by</li></ol>	t the s. ate nift.	
	would call the physici tract infection (UTI).	an for a possible Urinary			The Director of Nursing and/or     Administrative Nurse will audit all     physician orders 5 times a week for on	e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345184	B. WING			C 08/03/2018		
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	103/2016	
					1 SOUTH HALSTEAD BOULEVARD			
CONCOR	DIA TRANSITIONAL CA	ARE & REHAB-ELIZABETH CITY			LIZABETH CITY, NC 27909			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 658	Continued From pa	ge 25	F 6	658				
	physician had confi to check for possibl A review of the physician an interview nurse unit manager physician's orders wand the labs were considered to be a considered to be drawn. Someone else the labon revealed staff into the computer sthrough. The DON signal considered to be drawn.	e note on 6/19/18 revealed the rmed a urinalysis on 6/20/18, e UTI. sician 's order dated 6/19/18 or urinalysis on 6/20/18.  on 8/3/18 at 8:51 AM the stated that normally the were placed on the lab sheet drawn. She stated she did not lysis not been done.  on 8/3/18 at 9:05 AM the (DON) stated their process sysician 's order in the lab She expected staff should alph with the order or told alb needed to be drawn. The had put the physician 's note of they should have followed stated staff were calling the ne still wanted the urinalysis.			month, then 2 times a week for 2 monto ensure physician orders are followed per professional standards.  5. Data results will be reviewed and analyzed at the center's monthly Qual Assurance and Performance Improvement meeting for three month with a subsequent Plan of Correction needed.	ed ity s		
	facility on 8/31/17 w Chronic Obstructive Fibrillation, Hyperte Type 2 Diabetes Me Communication De recent Minimum Da Resident # 138 was making and he requ most areas of activi Review of hospital of dated 2/6/18, read if Pt 24- Use 9.5 mg.	as originally admitted to the with diagnoses including a Pulmonary Disease, Atrial ension, Alzheimer's Disease, allitus and Cognitive ficit. According to the most atta Set (MDS) dated 2/15/18, as independent in decision uired extensive assistance in ties of daily living.  discharge medication orders in part, "Exelon 9.5 mg/24 hr. to affected area once a day." readmitted to the hospital						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
		345184	B. WING _		ns ns	C 3/ <b>03/2018</b>
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAR	E & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909		103/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 658	again on 2/10/18, who Exelon patch was las other patches were not buring an interview of Director of Nursing (E#138 was discharged through 2/6/18. She readmitted back to the order for an Exelon pose applied, removed She explained Reside the hospital again on patch dated 2/6/18 have placed. The DON reorders from the hospitated she did not know removed and replace that a meeting was he family member and sign patches.	en it was determined the treplaced on 2/6/18 and of placed for three days.  In 8/1/18 at 1:00 PM, the DON) revealed Resident to the hospital from 2/2/18 evealed when he was e facility on 2/6/18, he had a atch which was supposed to and replaced every 24 hrs. ent #138 was discharged to 2/10/18 and an Exelon and not been removed and evealed the discharge tal were not followed. She ow why the patch was not d daily. The DON explained eld with Resident #138's ne did in services and audits	F6	58		
F 684 SS=D	applies to all treatment facility residents. Bas assessment of a resident residents receive accordance with profes practice, the compreheare plan, and the residents.	ndamental principle that int and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of inensive person-centered	F 6	84		8/29/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345184	B. WING _				C <b>03/2018</b>	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2010	
					01 SOUTH HALSTEAD BOULEVARD			
CONCOR	DIA TRANSITIONAL CAR	E & REHAB-ELIZABETH CITY			LIZABETH CITY, NC 27909			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684		ns, record review and	F	684	Resident #33's ted hose was applie			
	provide compression physician to treat low	erviews, the facility failed to stockings as ordered by the er extremity edema for 1 of			8/03/2018 and checked daily, resident was assessed for pain on 8/03/2018 w no pain indicated.			
	(Resident #33) and fatimely manner for a re	vith compression stockings alled to provide care in a esident exhibiting signs of all with a change in condition			2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 with current resident population to ensure those with	h		
	3/10/15 with diagnose Mellitus, Chronic Isch Hemiplegia and Hem	emic Heart disease, iparesis following a			ted hose have proper placement and residents that have physician orders fo pain medication to assure medication is given timely.			
	Data Set (MDS) Asset identified Resident #3 impaired. He did not extensive two person transferring and requirements.	ecent quarterly Minimum essment dated 6/14/18 83 as moderately cognitively exhibit behaviors. He was an assist with bed mobility and ired extensive one person g. Resident #33 had both emity range of motion			3. The Staff Development Coordinator and/or Administrative Nurse re-educate Licensed Nurses 8/24/2018 on applyinted hose as ordered and administering medication in a timely manner for residents as per physician orders. Staf not available for training by set date wieducated before next working shift. The Director of Nursing and Interdisciplinar Team will review residents with physici orders to apply ted hose and pain medication weekly in Standards of Car	f II be e y an		
	documented a Focus impaired circulation a extremities related to interventions in place stockings as ordered.  Review of the Physici revealed an order for knee high stockings -	Plan, revised on 3/27/18, area of resident having nd/or edema to the lower Diabetes and diet. The included compression fan's Order dated 2/8/16 compression stockings - Apply in AM (morning) and ng) one time a day for			meeting to ensure ongoing compliance  4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit 5 reside pain assessments and Medical Administration Record (MAR) for residents that have physician order for pain medication 5 times a week for 1 month, then 2 times a week for 2 mont	nts		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345184	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	040104		STREET ADDRESS, CITY, STATE, ZIP CODE		08/03/2018	
NAME OF F	ROVIDER OR SUFFLIER						
CONCOR	DIA TRANSITIONAL CA	RE & REHAB-ELIZABETH CITY		901 SOUTH HALSTEAD BOULEVARD			
				ELIZABETH CITY, NC 27909			
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From pag	je 28	F 6	84			
	Edema.			to ensure pain medication is gi timely manner.	ven in a		
	(TAR) for 2/2018 threknee high stockings  Observations on 7/3 #33 was sitting up in table for lunch. His swollen. He was no stockings.  During an observation Resident #33 was si ankles were noted to wearing compression.  During an observation Resident #33 was in wearing compression.	on on 7/31/18 at 3:52 PM bed sleeping. He was not		The Director of Nursing, Staff Development Coordinator, and Administrative Nurse will audit physician orders for ted hose 3 week for one month, then once 2 months to assure care plan is appropriate, physician order in ted hose being applied.  5. Data results will be reviewed analyzed at the center's month Assurance and Performance Improvement meeting for three with a subsequent Plan of Cornneeded.	5 resident B times a e a week for s place, and d and bly Quality e months	or	
	PM she stated she had resident needed constated he did not had unless he was up in  During an interview of Director of Nursing stockings should had During an interview 8/3/18 at 10:40 AM states.	with NA #1 on 8/1/18 at 2:28 had never been told the hopression stockings. She we any swelling in his ankles					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY DMPLETED
		345184	B. WING _			C 08/03/2018
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CA	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP COD 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag	ge 29	F	684		
	1/29/18 with diagno Atherosclerotic Hea and Chronic Respirastatus. Review of the most Data Set (MDS) Assidentified Resident Review of the Nursi no documentation frassessment done b 12:30 PM.  Review of the Nursi an entry at 3:00 PM resident having gen His temperature wa 18 and blood pressigiven for a fever.  Review of the Nursi Director of Nursing, documented Reside oxygen saturation le oxygen via nasal catemperature was 10 note documented the self and was lethard Practitioner was in the New orders were with and Bactrim (antibid was notified.  During an observati 12:16 PM he was of	admitted to the facility on ses including Atrial Fibrillation, rt disease, Dysphagia, Acute atory Failure and Gastrostomy recent quarterly Minimum sessment dated 5/7/18 #7 as cognitively intact. In the Note dated 8/1/18 showed from Nurse #1 related to an any this nurse on 8/1/18 at the Note of Section 19 Note dated 8/1/18 showed from Nurse #1 reflecting eralized complaints of pain. In the Section 19 Sect				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345184	B. WING _			C 8/03/2018		
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CA	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP OF SOUTH HALSTEAD BOULEVARY ELIZABETH CITY, NC 27909	CODE	0/00/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SH		(X5) COMPLETION DATE		
F 684	Continued From pag	ge 30	F	684				
	noted to be rolling ir air conditioner was degrees and Reside	s pale in color. His eyes were n an upwards direction. The observed on at a setting of 72 ent #7 was under his blanket.						
	Nurse #1 entered R the resident. Resident nurse he hurt all over	on on 8/1/18 at 12:30 PM esident #7s room to assess ent #7 was heard telling the er. His blood pressure was killary temperature was 98.6						
	degrees Fahrenheit cannula at 2 liters, h at 60 cc and hour an had some wheezing	his Oxygen was on via nasal his gastrostomy was running and Nurse #1 stated his lungs and he felt a little clammy hirse #1 was observed to give						
	12:16 PM he stated	with Resident #7 on 8/1/18 at he did not feel well and was gs. He stated he had told did not recall who.						
	12:18 PM she stated during medication phe never complaine maybe he told the Napain. She further stataking care of Resid know him. She stated	with Nurse #1 on 8/1/18 at d she had seen the resident ass earlier in the morning and d of any pain. She stated lursing Assistant about the ated she was not used to ent #7 and really did not ed Resident #7's roommate sident #7 had not been						
	NA #4 came to her of told her he was not take his vital signs a good. She stated cli "he didn't look right. done a physical ass	uple of days. She stated when earlier about the resident and looking right, she had NA #4 and his vital signs looked nically nothing was wrong, but "She stated she had not essment such as listening to hing yet because his vital						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCT  A. BUILDING			ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345184	B. WING _				C 03/2018	
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAR	E & REHAB-ELIZABETH CITY		901	REET ADDRESS, CITY, STATE, ZIP CODE  SOUTH HALSTEAD BOULEVARD  IZABETH CITY, NC 27909	, 50.	30,20.10	
(X4) ID PREFIX TAG			ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	e 31	F	684				
		ne stated she really did not Il and she would assess the						
	PM she stated she gas Resident #7 and was eyes looked a little fu who asked her to get got vitals and told the During a follow-up int 8/1/18 at 1:11 PM she another nurse in to lo she didn't know who hot know who the uni During an interview was care physician on 8/3 that the resident shouthe nurse when the N	erview with Nurse #1 on e stated she had not taken ok at the resident because to tell. She stated she did at supervisor was. with Resident #7's primary with Resident #7's primary wild have been assessed by A informed her of changes. umented an assessment						
	8/3/18 at 10:40 AM si should have been as: Assistant came to the She stated taking vita Following the assess entered information re the computer. The ni charge and could have	with the Administrator on the stated Resident #7 sessed when the Nursing a nurse about a change. It signs isn't enough, ment the nurse should have elated to her assessment in the urse knew who was in the had the Unit Manager or to in to assess the resident						
F 688 SS=D	CFR(s): 483.25(c)(1)-	crease in ROM/Mobility -(3)	F 6	888			8/29/18	
	§483.25(c) Mobility. §483.25(c)(1) The fac	cility must ensure that a						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345184	B. WING _			0:	C 8/03/2018
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CA	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP C 901 SOUTH HALSTEAD BOULEVAR ELIZABETH CITY, NC 27909		, ,	3.20.2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Continued From page	ge 32	F	886			
	range of motion doe range of motion unle condition demonstrate of motion is unavoid.  §483.25(c)(2) A resimption receives appropriate assistance to maintathe maximum practireduction in mobility. This REQUIREMEN by:  Based on observati interviews, the facilit services and passiv	the facility without limited as not experience reduction in less the resident's clinical ates that a reduction in range lable; and  dent with limited range of propriate treatment and arange of motion and/or to lease in range of motion.  dent with limited mobility as services, equipment, and lain or improve mobility with cable independence unless a lar is demonstrably unavoidable. It is not met as evidenced at on, record review and staff the failed to provide splinting arange of motion for the ment for 1 of 1 residents			1. Resident #33's splint was applied of 8/03/2018 by Certified Nursing Assistand checked daily; PROM given to resident on 8/03/2018 by Certified Nu	ant	
	(Resident #33) review mobility.  The findings include	ewed for range of motion and			Assistant and ongoing.  2. The Director of Nursing, Staff Development Coordinator, and/or		
	Resident #33 was a 3/10/15 with diagno Mellitus, Chronic Iso Hemiplegia and Her	dmitted to the facility on ses including Diabetes chemic Heart disease, miparesis following a cident and Dementia.			Administrative Nurse performed a one-time audit 8/17/2018 with current resident population to ensure resident with splints have proper placement ar residents with PROM orders are being followed.	s id	
	3/16/18 documented Activities of Daily Linhad contractures.	Area Assessment dated d Resident #33 required ving (ADL) assistance and n 2018 Occupational Therapy			3. The Staff Development Coordinator and/or Administrative Nurse re-educa nursing staff 8/24/2018 on applying spas per physician order and providing PROM as per physician order. Staff navailable for training by set date will be	te all plint ot	

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345184	B. WING				C 03/2018
	OVIDER OR SUPPLIER	E & REHAB-ELIZABETH CITY	1	STREET ADDRESS, CITY, STATE, ZIP CODE  901 SOUTH HALSTEAD BOULEVARD  ELIZABETH CITY, NC 27909		<u> </u>	00/2010
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 688	Continued From page	e 33	F	688			
	assessment documer was at 86 degrees to range of motion.  Review of the Physici read Resident #33 wa Occupational Therapy was to receive passiv to the left shoulder, el prior to putting on a h support.  Review of the Care P documented a Focus having an ADL Self-carelated to his Cerebrothemiparesis (left side in meeting the goal of of function included a Review of the most reducted to the prior to putting on a host part of the prior to putting on a host prior to putting on a h	an's Order dated 4/3/18 as discharged from y services. The resident e range of motion (PROM) lbow, wrist and digits daily and splint with built up digit  lan, revision date 5/21/15, area for Resident #33 are performance deficit ovascular Accident with d weakness). Interventions f improving the current level left-hand splint as ordered.  ecent quarterly Minimum essment dated 6/14/18 33 as moderately cognitively exhibit behaviors. He was an assist with bed mobility and red extensive one person g. Resident #33 had both emity range of motion le. He was not receiving Doccupational therapy. He ive nursing program or		688	educated before next working shift. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurs will ensure splint application and PRON are completed by observation and reviewing audit in Clinical Morning meeting.  4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit 5 reside with splints for placement and PROM being performed 3 times a week for 1 month, then once a week for 2 months.  5. Data results will be reviewed and analyzed at the center's monthly Qualit Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction a needed.	se /I nts	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345184	B. WING _			C 08/03/2018	
	ROVIDER OR SUPPLIER	ARE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP COL 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909		56/66/2016	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 688	Continued From pa	ge 34	F 6	88			
	AM he was up in his was observed with and there was no via the observations on 7/3 Resident #33 in his place in his contract Observations on 7/3 Resident #33 in begin his contracted left Observations on 8/4 Resident #33 in begin his contracted left Observations on 8/4 Resident #33 was it place in his contract Observations on 8/5 Resident #33 in begin his contract Observations Observations Obse	31/18 at 3:52 PM revealed d with no hand splint in place it hand.  1/18 at 7:51 AM revealed d with no hand splint in place it hand.  1/18 at 11:28 AM revealed n bed with no hand splint in ted left hand.  2/18 at 8:06 AM revealed d with no hand splint in place					
	Nursing Assistant (I with Resident #33 of shift, she stated the splits and had never resident. She further left hand at all.  During an interview Therapist (O.T.), will March 2018 and Au 8/02/18 at 8:42 AM	on 8/01/18 at 9:08 AM with NA #1), who frequently worked on the 7:00 AM to 3:00 PM resident did not wear wrist or placed hand splints on the er stated he could not use his with the Occupational no had completed both the igust 2018 assessment, on she stated Resident #33 had splint and in March 2018 a					

<u> </u>	C I CIT III EDIOTITE G	T CERTIFICATION OF THE PROPERTY OF THE PROPERT				<del></del>	7. 0000 0001	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BOILD			,	c	
		345184	B. WING				03/2018	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				9	01 SOUTH HALSTEAD BOULEVARD			
CONCOR	DIA TRANSITIONAL CAF	RE & REHAB-ELIZABETH CITY		E	LIZABETH CITY, NC 27909			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX	,	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	∤IE	DATE	
			-					
F 688	Continued From page	e 35	F	688				
		d. She stated she worked for		000				
		eeks with the resident doing						
		tion and using the hand						
		ated at the end of two weeks						
	· ·	se and the nursing assistant						
		and when to use it. She						
		restorative program at the						
		at the nursing assistants were						
	_	the passive range of motion						
		nt. She stated she had						
		ne top dresser drawer. The						
	O.T. and State Agend	cy (SA) walked down to						
		and the O.T. pulled the						
	splint out of the top d	lresser drawer and showed						
	the SA and NA#3, wh	no was in the room, how it						
		#3 stated, "Ok." The O.T.						
		sident's left elbow and stated						
		tempted to move the left						
		e was tight. She stated she						
		on and most likely place an						
		eft elbow to keep the elbow						
		ure. She stated it was very						
	· •	ROM exercises to keep the						
		tight. She then stated she						
		s in March 2018 to the						
	_	resident was to wear the						
		day during the 7am-3pm shift n completed during his						
		irther documented on the						
	_	ion that upon arrival on						
	_	presented supine in bed with				ĺ		
		arded position on his chest.				ſ		
		esident did not exhibit this				ĺ		
		in after 10 degrees of				ſ		
		tion, displaying increase				ĺ		
	ı · •	ertonicity (tightness). She				ĺ		
		dent would benefit from a full				ĺ		
	OT evaluation for the					ĺ		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345184	B. WING			C 8/03/2018	
	ROVIDER OR SUPPLIER	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909		1 00/03/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 688	Resident #33 he star all day.	on 8/02/18 at 1:32 PM with ted he had not had a splint on	F€	588			
	PM she stated she do her shift today that N During an interview PM she stated she h resident before today	with NA #2 on 8/02/18 at 1:34 ad not worked with the y and had no idea he was to id not state if PROM had					
	8/02/18 at 1:34 PM s with the resident bef been a splint in the r	terview with NA #3 on she stated she had worked ore and there had never oom to place on him. She did ne did PROM with Resident					
	8/02/18 at 2:14 PM I left-hand splint did n Administration Reco	with the Nurse Consultant on the stated the resident's of get on the Medication and because the nurse keyed it showed up to be applied to and.					
	Director of Nursing s hand splint was not to Medication Administ the Kardex. She stat from the care plan at could see this in poin nursing station, on the hand-held device. St motion should have	on 8/2/17 at 2:48 PM with the the stated the order for the transferred correctly to the ration Record but it was on the teach of the Kardex was created and the nursing assistants and the care, either at the ne wall station or their ne stated passive range of the been completed during the and splint should have been in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345184	B. WING _				C / <b>03/2018</b>
NAME OF PROVIDER OR SUPPLIE  CONCORDIA TRANSITIONA		RE & REHAB-ELIZABETH CITY		ç	STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	1 00	70072010
PREFIX (EACH DEF	ICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
was unsuccess During an interv 8/3/18 at 10:40 should have be performed and Nutrition/Hydrat SS=D  \$483.25(g) Ass (Includes naso- both percutaneous e enteral fluids). comprehensive ensure that a re  \$483.25(g)(1) N of nutritional sta desirable body balance, unless demonstrates th preferences ind  \$483.25(g)(2) Is maintain proper  \$483.25(g)(3) Is there is a nutriti provider orders This REQUIRE by: Based on obse interviews the fr address weight for nutritional st	ontactive vision of the care in the care i	t Resident #33's physician uring the survey. with the Administrator on the stated the hand splint in passive range of motion are plan followed. Status Maintenance 0-(3)  nutrition and hydration. ic and gastrostomy tubes, indoscopic gastrostomy and copic jejunostomy, and don a resident's intensional states as usual body weight or intensional acceptable parameters such as usual body weight or intensional acceptable or resident otherwise; ired sufficient fluid intake to ration and health; ired a therapeutic diet when problem and the health care		688		า	8/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  3		(X3) DATE SURVEY COMPLETED	
						С	
		345184	B. WING		08	3/03/2018	
NAME OF PI	ROVIDER OR SUPPLIER	•	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO			
				901 SOUTH HALSTEAD BOULEVARD	)		
CONCOR	DIA TRANSITIONAL C	ARE & REHAB-ELIZABETH CITY		ELIZABETH CITY, NC 27909			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF O	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	HE APPROPRIATE	COMPLETION DATE	
F 692	Continued From page	age 38	F 69	92			
	reviewed for nutriti	on (Resident #33).					
		(		2. The Director of Nursing, S	Staff		
	The findings include	led:		Development Coordinator, a			
				Administrative Nurse perform	med a		
		as originally admitted to the		one-time audit 8/17/2018 wi	ith current		
		with diagnoses including		resident population in the la			
		(Generalized), Alzheimer's		ensure they have been add			
		sion and Dysphagia		interventions. In addition to	•		
		ase. According to the most		residents with supplement of			
7/4/18, Resident #50 was cognitively impaired and required extensive assistance in most areas			ensure residents have corre and are receiving per physic				
		and are receiving per physic	ciali olueis.				
				3. The Staff Development C	Coordinator		
	or donvince or daily	, inving, including calling.		and/or Administrative Nurse			
	Review of a Dietic	an's (RD) Nutrition		all Licensed Nurses 8/24/20			
		6/29/18, read in part, "Medical		providing supplements as p	er physician		
	Nutrition therapy re	eview completed. See		order and addressing weigh	it changes with		
		tails. Summary of review:		Registered Dietitian. Staff n			
		ike by mouth greater than 50%.		training by set date will be e			
		bal prompts during meals.		before next working shift. The			
	_	tolerated. Continue with Plan of		Nursing and Interdisciplinary			
		eed to Care Plan." The RD's		review weight changes wee	•		
		ot address that Resident #50		Standards of Care meeting.			
	2018 to May 2018	recent weight loss from April		4. The Director of Nursing, S	Staff		
	2010 to May 2010	•		Development Coordinator, a			
	Review of the facil	ity Dietician's progress note		Administrative Nurse will au			
		ealed Resident #50's weight		receiving supplements to as			
		. She had a weight loss in April,		supplements are being give			
		etiology. Weight has been		physician order and all resid	•		
	stable for past thre	e months. Resident #50's body		weight changes are address	sed with		
		7.9 and the resident was		interventions 3 times a weel			
		ideal body weight was 110		then once a week for 2 mon	iths.		
		ent's intake by mouth was					
		dependence on feeding per		5. Data results will be review			
		uage Pathologist evaluation		analyzed at the center's mo			
		exture being given. Regular		Assurance and Performance			
		xture, Ensure three times daily provide for needs. The RD's		Improvement meeting for th with a subsequent Plan of C			
	i si ioulu continue to	provide for fields. The RDS	1	with a subsequent Plan of C	JULIECTION 92	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345184	B. WING		C 08/03/2018	
NAME OF PROVIDER OR SUPPLIER  CONCORDIA TRANSITIONAL CAR	E & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	1 30/06/2010	
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
had experienced a red between April 2018 and Review of Resident #8 7/12/18, which continue the resident had a nut mouth varied. Resider significant weight char greater than 75%. The daily weights times 4 weeks ordered. Monitor weights as available.  Review of Resident #8 period revealed the refollowing weight loss:  1/3/18 163 2/12/18 165 3/10/18 165 3/10/18 165 5/1/18 152.8 (note a 7 4/10/18) 6/27/18 153 7/9/18 152 pounds  During a breakfast obs 8/2/18 at 8:53 AM, Nurevealed a week to a west on the sident #50 was not eating as Resident #50 was eat doing much better now did not get supplements would not eat any	address that Resident #50 cent weight loss specifically ad May 2018.  50's Care Plan dated used from 7/12/17 revealed ritional risk as her intake by at #50 had a goal for no age with intake by mouth no e interventions included ree weeks, then weekly s. Diet supplements as hts, intake by mouth and  50's weights for a six month sident had experienced the  7.4 % weight loss since  servation and interview on arsing Assistant (NA#5) week and a half, Resident	F 692	needed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345184	B. WING_			C 98/03/2018	
	ROVIDER OR SUPPLIER	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODI 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909		10/03/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 692	facility Dietician statilost weight and she by not updating the address the weight I #50 had been fine for speech therapist had She stated they wer loss and she didn't ke document it. The Dieput intervention(s) in 50's recent weight lost of the Dietician would look would make a note in During an interview Director of Nursing (gained a lot of weight admitted to the facility pounds here and the tothe Dietician to mit #50's weight loss. Shenefited her to lose level was abnormal. Should have address time of the weight lothing for Resident #50's Care Resident #50's	on 8/2/18 at 1:30 PM, the ed she knew Resident #50 said she must have missed it resident's care plan to oss. She revealed Resident or several years and the devaluated her for texture. The concerned about her weight know why she did not edician confirmed she did not a place to address Resident oss.  On 8/2/18 at 1:52 PM, the vealed the last time Resident is supdated was 7/12/18. She so had weight loss, the at any weight changes and if there was a weight change.  On 8/2/18 at 3:17 PM, the DON) revealed Resident #50 in when she was initially the she gained a few ere. She stated it would be up take a note about Resident he stated it would have a weight because her thyroid She revealed the Dietician sed the weight loss at the set and even if it was a good to lose weight, the e documented it. She stated ected the Dietician to update	F 6	92			
		ed her expectation would be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONS		(X3) DATE SURVEY COMPLETED		
		345184	B. WING _			1	C <b>03/2018</b>	
	ROVIDER OR SUPPLIER	I RE & REHAB-ELIZABETH CITY			ADDRESS, CITY, STATE, ZIP CODE JTH HALSTEAD BOULEVARD	1 00/	03/2010	
CONTOCIN	SIA TRANSITIONAL SAI	te a nema ellende mom		ELIZAE	BETH CITY, NC 27909			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 692		ıld address weight loss and eight loss and implement	F€	92				
	2. Resident #33 was 3/10/15 with diagnost Mellitus, Chronic Isch Hemiplegia and Hem Cerebrovascular Acc	nemic Heart disease, iparesis following a						
	Data Set (MDS) Asset identified Resident #3 impaired. He did not extensive two person transferring and requipassistance with eating upper and lower extra impairment to one sid Speech, Physical or 6	le. He was not receiving Occupational therapy. He ive nursing program or						
	documented an order nutritional supplement per day at 8AM, 12PI Review of the Medica (MAR) for 2/2018 through order for a Glucose Co	ation Administration Record ough 8/2018 documented an						
		lan, revised on 10/11/17, area for Resident #33 being						

	ATEMENT OF DEFICIENCIES OPLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  ———————————————————————————————————			(X3) DATE SURVEY COMPLETED		
		345184	B. WING _			C 08/03/2018
	ROVIDER OR SUPPLIER	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP C 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	ODE	50,00,2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 692	Review of Resident documented a 2/12/his recorded weight This reflects an 8.99 Review of Resident 3/13/18 documented change. His current intake was 50-100% supplements three to changes were recording difficulty which included coughysical findings we current weight was 2 recommendations we documentation relations on 8/1	#33's weight record 18 weight of 220 pounds and on 8/2/18 was 200.5 pounds. 6 weight loss in six months. #33's Nutritional note dated on significant weight weight was 218 pounds. His on the was receiving imes per day. No nutritional numended. #33's Nutritional Therapy of the was receiving imes per day. No nutritional numended. #33's Nutritional Therapy of the was receiving imes per day. No nutritional numended. #33's Nutritional Therapy of the was receiving imes per day. No nutritional numended. #33's Nutritional Therapy of the was no besity. His 207 pounds. No new were made. There was no ed to weight loss.	F	692		
	Observations on 8/1 not reveal any supp bedside table or me During an interview 9:07 AM she stated Glucose Control sup but she did not know giving this to the restrom dietary.	not reveal any supplement on de table or meal tray.  /18 at 1:03 PM of lunch did lement on the resident's al tray.  with Nurse #1 on 8/1/18 at the resident received a oplement three times daily, who was responsible for ident and stated it must come  with Nursing Assistant (NA) #				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	· , ,	(X3) DATE SURVEY COMPLETED		
		345184	B. WING _			C 8/03/2018		
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CA	ARE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CO 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909		6/03/2016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 692	did not have a supp she thought the nur During an interview 8/02/18 at 9:22 AM responsible for supp that nursing provided During an interview on 8/2/18 at 9:49 Al should be getting stop During an interview on 8/2/18 at 10:01 A are given by the nur medication cart. The supplements an supplement isn't give it as given.  During a follow up in 8/02/18 at 10:15 AM documented the Glugiven on the MAR be supplements come tray and she assum supplements. She signed the supplements of the supplements.	AM she stated the resident element on his meal tray and se gave that to him.  with the Dietary Manager on she stated dietary was not elements on the meal trays ed supplements.  with the Registered Dietician M she stated Resident #33 applements with med pass.  with the Director of Nursing AM she stated all supplements	F 6					
	Glucose control sup room and the facility supplement ordered During a follow up in Dietician on 8/02/18 about six months ag the glucose control	he stated she went to get a splement from the supply of did not have the type of did.  Interview with the Registered at 10:35 AM she stated that go the facility stopped carrying supplement that Resident #33 She stated she did not know						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '			E SURVEY  MPLETED	
		345184	B. WING			C 98/03/2018	
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAI	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	1 0	16/03/2018	
(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 CORREC' ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 693 SS=D	why this was not add any notes and stated not received the gluc supplement since the longer. She further siduring the last six moshe probably would rive because Resident #3 weight.  During an interview was 8/02/18 at 2:14 PM in supplements about 60 changed on Resident know if the resident in supplement.  During an interview was 8/3/18 at 10:40 AM is supplements should. Tube Feeding Mgmt/CFR(s): 483.25(g)(4)-(5) En (Includes naso-gastric both percutaneous endosenteral fluids). Based comprehensive asseen sure that a resider \$483.25(g)(4) A resideral methods unless condition demonstrations.	Iressed or the weight loss on I the resident probably had cose control nutritional e facility did not carry that any stated he did drop weight onths; however, she stated not have made any changes 33 was still above his ideal with the Nurse Consultant on the stated the facility switched is months ago and it was not to the stated the facility switched in a month and received an alternative with the Administrator on the stated the nutritional have been given as ordered. (Restore Eating Skills 1)(5)  Iteral Nutrition ic and gastrostomy tubes, andoscopic gastrostomy and do not a resident's ssment, the facility must	Fé	993		8/29/18	

PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345184	B. WING		0.5	C 3/03/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	5/03/2016	
	(0.11)			901 SOUTH HALSTEAD BOULEVARD			
CONCOR	DIA TRANSITIONAL CAI	RE & REHAB-ELIZABETH CITY		ELIZABETH CITY, NC 27909			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH		HOULD BE	(X5) COMPLETION DATE	
F 693	Continued From page	e 45	F 6	93			
1 093	§483.25(g)(5) A reside means receives the asservices to restore, if and to prevent compincluding but not limit diarrhea, vomiting, deabnormalities, and nathis REQUIREMENT by:  Based on observation and staff interviews, administer nutrition that as ordered, for 24 hot the correct amount g (Resident # 46) observation.  The findings included Resident # 46 was resident # 46	dent who is fed by enteral appropriate treatment and possible, oral eating skills lications of enteral feeding and to aspiration pneumonia, ehydration, metabolic asal-pharyngeal ulcers.  To is not met as evidenced on, medical record review, the facility failed to anough a gastrostomy tube aurs, and failed to document aiven for 1 of 2 residents arved for tube feeding.	FO	1. Resident #46's feeding bottle tubing was changed and pump s re-programed by Director of Nur 7/31/2018 at 1:00 pm; then feed continued as per physician order  2. The Director of Nursing, Staff Development Coordinator, and/o Administrative Nurse performed one-time audit 8/17/2018 with cu	settings rsing on ling r.  or a urrent		
	sclerosis, and gastro percutaneous endos	oses to include multiple stomy status with copic gastrostomy tube //inimum Data Set (MDS)		resident population on all resider eternal feedings to ensure feeding given as per physician order.			
	assessment dated 6/ cognition to be sever required extensive to for activities of daily I	27/2018 revealed her		3. The Staff Development Coord and/or Administrative Nurse re-eall Licensed Nurses 8/24/2018 of feeding administration. Staff not for training by set date will be edbefore next working shift. The Di	educated on eternal available ducated		
		onic medical record revealed evious 6 months to be as nds (#)		Nursing, Staff Development Cocand/or Administrative Nurse will eternal feedings are given as orduring observation and audits the reviewed in Clinical Morning med.  4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit 5 receiving eternal feeding to assume the coordinate of	ordinator, ensure dered lat will be eting. or		

Facility ID: 943207

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345184	B. WING			1	C / <b>03/2018</b>	
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAI	RE & REHAB-ELIZABETH CITY		90	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HALSTEAD BOULEVARD LIZABETH CITY, NC 27909	1 00	700/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 693	Physician Orders datorders as follows:  Enteral nutrition: 150 of Jevity (nutrition) 1.900 cc in 24 hours.  Flush feeding tube wwater every 4 hours.  Resident #46s Medic (MAR) for July 2018 7/30/2018 and 7/31/27/30/2018:  Day 360 ml nu 300 ml water sevening 360 MLF 300 MLW  Night 360 MLF 300 MLF 300 MLW  7/31/2018:  Day 360 MLF 300 MLF 300 MLW	ted for July 2018 included  cubic centimeters (cc) bolus 5 every 4 hours for a total of  with 100 milliliters (ml) of  cation Administration Record recorded on the date of 2018 the following:  ctrition feeding (MLF)  er (MLW)	F	693	supplements are being given as per physician orders are being followed an infusing properly 3 times a week for 1 month, then once a week for 2 months  5. Data results will be reviewed and analyzed at the center's monthly Quali Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction a needed.	ty		
	conducted of a tube of the front of the bottle marker and dated as The bottle appeared tubing which ran thru pump. The face of the mile every 4 hours and	AM, an observation was feeding for Resident # 46. was written on with a black 7/30 start 1330 (1:30 PM). full and was connected to an electronic programmable he pump showed flush 100 was running with 501 ml l/hour bolus, with 0 bolus						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONST		(X3) DATE SURVEY COMPLETED		
		345184	B. WING _			1	C <b>03/2018</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	1 00.		
CONCOR	DIA TRANSITIONAL CAI	RE & REHAB-ELIZABETH CITY		901 SOU	ITH HALSTEAD BOULEVARD			
				ELIZAB	SETH CITY, NC 27909			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT 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 693	Continued From pag	e 47	F 6	93				
		ull unopened bottle was lying set of drawers across from						
	conducted of Reside	PM, an observation was nt #46s tube feeding bottle, bottle dated as 7/30 start ed full.						
	conducted with Nurs Resident #46, who s been erased becaus much feeding had be requested to get som Nurse #3. Nurse #3 hanging with an unop the bottle was full an Nurse #5 stated she manually with syring today as there was in the room, and she us feeding today. The refeeding was give	2 PM, an interview was e #5 at the bedside of tated the pump must have e she was unable to see how een recorded. The nurse he help and returned with measured the full bottle bened full bottle and stated d was good for 48 hours. sometimes fed the resident e, but she did not do that no other bottle of feeding in sed the pump to deliver the hurse stated she documented in on the MAR because she mount of feeding the resident						
	conducted with the D the bedside of Resid feeding bottle was fu had only delivered w The DON stated if th changed the bottle w but since there was r whole set up would b On 8/1/2018 at 7:48	2 PM, an interview was Director of Nursing (DON) at ent # 46 and stated the Il and it appeared the pump ater and not the feeding. e tubing had not been rould be good for 48 hours, no date on the tubing the be changed now.  AM, an interview was e #10. The nurse stated she						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345184	B. WING_			C 98/03/2018	
	ROVIDER OR SUPPLIER	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP COD 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	•	10/03/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 693	feeding had been de observed the bottle of was 600 to 700 ml le stated she figured up given during her shift documented on the bottle was full enough changed on her shift On 8/1/2018 at 7:59 conducted with Nursworked on the 11:00 night of 7/30/2018. Resident #46 medica AM, and she noticed 7/30, but did not look stated she would ad closely at the bottle being delivered.  The nurse who hung 1:30 PM was an age unavailable for intervolution of 8/3/2018 at 8:07 conducted with Nurs The nurse stated she feeding amount as 3 because she had the MAR to click a butto documented and did the amount should be on 8/3/2018 at 8:07 conducted with the E expected the nurses	to 11:00 PM shift on locumented Resident # 46s slivered because when she dated 7/30 at 1:30 PM, there eff in the bottle. The nurse of what the amount should be and that is what she MAR. The nurse stated the shift that it did not need to be shift on the PM to 7:00 AM shift on the PM to 7:00 AM shift on the PM to 7:00 AM shift on the The Nurse stated she gave eation at midnight and 6:00 If the bottle was dated as a cat the time. The nurse emit that she did not look to make sure the feeding was shift on the shift on the feeding was shift on the feeding was shift on the shift on the feeding was shift on the shift on the feeding was shift on the feeding was shift on the shift of the feeding was shift on the feeding w	F 6	93			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		345184	B. WING _				C 03/2018
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAR	RE & REHAB-ELIZABETH CITY		9	STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 693	Continued From page	e 49	F 6	93			
		tube feeding pump and amount of tube feeding was					
F 756 SS=D	Drug Regimen Review CFR(s): 483.45(c)(1)(	w, Report Irregular, Act On (2)(4)(5)	F7	756			8/29/18
		imen Review. ug regimen of each resident east once a month by a					
	§483.45(c)(2) This red of the resident's medi	view must include a review cal chart.					
	irregularities to the att facility's medical direct and these reports mu (i) Irregularities included that meets the condition of this section for a (ii) Any irregularities or during this review mu separate, written report attending physician a director and director and director and the irregularity th (iii) The attending phyresident's medical rection has been taken be no change in the or physician should doct the resident's medical and the irregularity has been that action has been taken be no change in the or physician should doct the resident's medical and the irregularity has been taken be no change in the or physician should doct the resident's medical and the irregularity has been taken be no change in the or physician should doct the resident's medical and the irregularity has been taken be no change in the or physician should doct the resident's medical and the irregularity has been taken be no change in the or physician should doct the resident's medical and the irregularity has been taken be no change in the or physician should doct the resident's medical and the irregularity has been taken be no change in the or physician should doct the resident's medical and the irregularity has been taken be no change in the or physician should doct the resident's medical and the irregularity has been taken be not the or physician should be not t	de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist st be documented on a port that is sent to the not the facility's medical of nursing and lists, at a at's name, the relevant drug, e pharmacist identified. Visician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in I record.					
		cility must develop and procedures for the monthly					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			، ا	c
		345184	B. WING				03/2018
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CONCOR	DIA TRANSITIONAL CAI	RE & REHAB-ELIZABETH CITY		90	01 SOUTH HALSTEAD BOULEVARD		
OONOON	DIA TRANSPIONAL GAI	CE & REHAD-ELIZABETH ON I		E	LIZABETH CITY, NC 27909		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	limited to, time frame the process and step when he or she ident requires urgent action. This REQUIREMENT by: Based on observation interview, staff physic Consultant interview failed to identify and an antibiotic eye drop for antibiotic usage (Interview the findings included Resident #41 was ac 9/12/17 and re-admits.)	that include, but are not as for the different steps in as the pharmacist must take tifies an irregularity that in to protect the resident.  T is not met as evidenced ons, record review, staffician and Pharmacy the Pharmacy Consultant address the long-term use of or for 1 of 1 resident reviewed Resident #41).	F	756	1. Resident #41, charge nurse receive order to discontinue medication on 7/31/2018; medication discontinued 7/31/2018.  2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 with current resident population who receive anti-bi medication to ensure stop date.		
	Atrial Fibrillation.  Review of the most r Data Set (MDS) asso- identified Resident # cognitively impaired. antibiotic usage.  Review of the Medica dated 10/17/17 through the second that the	ecent quarterly Minimum essment dated 6/22/18 41 as being severely The MDS did not document ation Administration Records gh 8/3/18 documented ceiving Gentamycin Sulfate rops), one drop to both eyes			<ol> <li>The Staff Development Coordinator and/or Administrative Nurse re-educate all Licensed Nurses 8/24/2018 on obtaining stop dates for anti-biotics ordered. Staff not available for training set date will be educated before next working shift. The Director of Nursing a Interdisciplinary Team will review new anti-biotic orders in Clinical Morning meeting.</li> <li>The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit all anti-biotic orders for stop dates 3 times week for 1 month, then once a week for months.</li> <li>Data results will be reviewed and</li> </ol>	by and	
	_	n on 8/2/18 at 11:20 AM, her room sitting up in her			Data results will be reviewed and analyzed at the center's monthly Qualit	V	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345184	B. WING _				C 03/2018
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAR	RE & REHAB-ELIZABETH CITY		90	TREET ADDRESS, CITY, STATE, ZIP CODE D1 SOUTH HALSTEAD BOULEVARD LIZABETH CITY, NC 27909	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 756	drainage or redness was During an interview was 1:28 PM sho	e 51 s wearing glasses and no was noted in her eyes. with the Unit Manager on e stated she would need to ident was receiving the	F7	756	Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction a needed.		
	medication. The Unit a diagnosis for the mo- During an interview w Consultant on 8/2/18	t Manager did not return with					
	care physician on 8/3 sometimes folks com	with Resident #41's primary 1/18 at 9:07 AM he stated e in with chronic Blephritis tions. He further stated the ontinued yesterday.					
	8/3/18 at 10:40 AM si discontinued. She fur should have made a appropriate diagnosis	with the Administrator on the stated the eye drops were of the stated the pharmacist recommendation for an a for the use of the drops and medication should have					
	During an interview w on 8/6/18 at 2:47 PM the Pharmacy Consu addressed the usage was being used. The	ne Pharmacy Consultant nade and unsuccessful.  with the Pharmacy Consultant by telephone she stated that litant at the time should have of the medication and why it e Pharmacy Consultant litessed an appropriate stop on's usage.					
F 757		e from Unnecessary Drugs	F7	757			8/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345184	B. WING			l	03/2018	
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAR	RE & REHAB-ELIZABETH CITY		9	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 757	7 Continued From page 52		F:	757				
SS=D	CFR(s): 483.45(d)(1)	-(6)						
		sary Drugs-General. regimen must be free from An unnecessary drug is any						
	§483.45(d)(1) In exce duplicate drug therap	essive dose (including by); or						
	§483.45(d)(2) For ex	cessive duration; or						
	§483.45(d)(3) Without adequate monitoring; or							
	§483.45(d)(4) Withoutuse; or	it adequate indications for its						
	§483.45(d)(5) In the consequences which reduced or discontinu	indicate the dose should be						
	stated in paragraphs section.	ombinations of the reasons (d)(1) through (5) of this Γ is not met as evidenced						
	interview, physician i Consultant interview,				1. Resident #41, charge nurse receive order to discontinue medication on 7/31/2018. Pharmacy Consultant instructed by Nurse Consultant on 7/31/2018 to review all medications du each regular scheduled visit.			
	9/12/17 and re-admit	mitted to the facility on			2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 with current resident population who receive anti-bi medication to have a diagnosis.	otic		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345184	B. WING _		<u> </u>	08/	) 03/2018	
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, S	TATE, ZIP CODE	1 00.	0.20.10	
				901 SOUTH HALSTEAD B	OULEVARD			
CONCOR	DIA TRANSITIONAL CAR	RE & REHAB-ELIZABETH CITY		ELIZABETH CITY, NC				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 757	Continued From page	e 53	F 7	57				
	Data Set (MDS) asset identified Resident #4 cognitively impaired. antibiotic usage.  Review of the Medica dated 10/17/17 throug Resident #41 was red Solution 0.3% (eye dieach evening at bedt According to the pack sulfate ophthalmic so topical treatment of our During an observation Resident #41 was in wheelchair. She was drainage or redness was sufficient was in the solution of the pack sulfate ophthalmic solution and the solution of the pack sulfate ophthalmic solution.	ecent quarterly Minimum ressment dated 6/22/18 At as being severely The MDS did not document  ation Administration Records gh 8/3/18 documented beiving Gentamycin Sulfate rops), one drop to both eyes sime for redness/dry eye.  Rage insert Gentamicin lution 3% is indicated in the cular bacterial infections.  In on 8/2/18 at 11:20 AM, ther room sitting up in her was noted in her eyes.  With the Unit Manager on		and/or Administrat all Licensed Nurse obtaining a diagnor ordered. Staff not set date will be ed working shift. The review all anti-biot pharmacist to ensi  4. The Director of Development Coo Administrative Nur anti-biotic orders for week for 1 month, months.  5. Data results will analyzed at the ce Assurance and Pe Improvement mee	osis for anti-biotics available for training ucated before next. Director of Nursing vice orders monthly with ure diagnosis.  Nursing, Staff ordinator, and/or rise will audit all for diagnosis 3 times then once a week for the reviewed and enter's monthly Quality.	by vill th  a or 2		
	8/2/18 at 1:28 PM shiresearch why the research why the re	e stated she would need to ident was receiving the Manager did not return with edication.  With the Regional Nurse at 3:43 PM he stated the discontinued as of today.  With Resident #41's primary 1/18 at 9:07 AM he stated e in with chronic Blephritis tions. He did not confirm a stated the medication was		with a subsequent needed.	Plan of Correction a	is		

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345184	B. WING		C 08/03/2018
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAP	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	, 0000.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 759 SS=D	8/3/18 at 10:40 AM s discontinued. She fur should have made a appropriate diagnosis addressed when the been discontinued.  Attempts to contact transparent during survey were in the been discontinued.  Attempts to contact transparent during survey were in the properties of the properties of the should have also addressed the usage was being used. The should have also addressed the medication Free of Medication E CFR(s): 483.45(f)(1)  §483.45(f) Medication The facility must ensible statement or greater; This REQUIREMENT by:  Based on observation and staff interviews, a medication error of medication errors from a medication error from a medication error of medication error from a medication error from a medication error from the should be	with the Administrator on he stated the eye drops were of ther stated the pharmacist recommendation for an is for the use of the drops and medication should have the Pharmacy Consultant ande and unsuccessful.  With the Pharmacy Consultant by telephone she stated that altant at the time should have to of the medication and why it the Pharmacy Consultant dressed an appropriate stop on's usage.  For Rts 5 Pront or More  The Errors.  For is not met as evidenced ons, medical record review the facility failed to maintain less than 5%, with 5 m 25 opportunities, resulting rate of 20% for 3 of 4 the facility failed to maintain and the state of 20% for 3 of 4 the facility failed to maintain rate of 20% for 3 of 4 the facility	F 7		n no and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345184	B. WING		0.5	C 3/03/2018	
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAR	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	1 00	10312010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 759	was observed passin #5. The nurse was of tablets one at a time including a vitamin D tablet. The nurse was of medications in the and answered that shourse stated she neemedications, and mix nurse dispensed the applesauce to Resideresident 1 spray into suspension nasal sproportion of the property of th	on administration 2018 at 8:10 AM, Nurse #4 g medications to Resident bserved to dispensed 8 into a small plastic cup 1000 (international units) IU is asked to verify the number plastic cup and she counted he had 8 medications. The ded to crush the them with applesauce. The medications with the each nostril of Fluticasone ay.  Conciliation (medications of what was ordered), it was can order was written for he time per day for ticasone suspension nasal the Physician orders as 2 is one time a day for nasal.  AM, an interview was at #4, who stated she gave is of Vitamin D to make 2000 she said she had 8 tablets and 9. The Nurse stated she is 2 sprays in both nostrils as in The nurse then stated she	F 75	and/or Administrative Nurse re-e all Licensed Nurses 8/24/2018 or medication competencies and metest. Staff not available for training date will be educated before next shift. The Director of Nursing and Interdisciplinary Team will ensure medication error rate below 5% be reviewing audits and observation in Clinical Morning meeting.  4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit meter pass on all shifts 3 times a week month, then once a week for 2 meeting analyzed at the center's monthly Assurance and Performance Improvement meeting for three new with a subsequent Plan of Correct needed.	n using edication ng by set t working d e by n results or ledication for 1 nonths. and Quality nonths		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	PLE CONSTRUCTION IG	, ,	E SURVEY IPLETED
		345184	B. WING _			C B/ <b>03/2018</b>
	ROVIDER OR SUPPLIER	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP COD 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909		5/03/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 759	F 759 Continued From page 56 5mg tablets for a blood pressure of less than		F 7	59		
	110/75. The nurse rother medications to	eadied and dispensed 8 Resident #35.				
	discovered that the r	reconciliation, it was nurse had documented she on 7/31/2018 Diclofenac Gel Lasix 20mg at 8:47 AM.				
	listed as follows: Diclofenac Sodium of transdermally 4 time	the missed medications were  yel 1%, apply 4 grams s a day for pain. mg one time per day related				
	to essential hyperter	- · · · · · · · · · · · · · · · · · · ·				
	noted times for Diclo	• • •				
	conducted with Nurs the Lasix because sl medications, and she the medication was l put the Diclofenac G	04 PM, an interview was e #5, who stated she held he held the blood pressure e did not notify the Physician held. The nurse stated she el on the resident when she 00 AM, because that was I her treatments.				
	conducted with the I The DON stated she the Medication Admi give what was order wrong to document t when it wasn't given to be given if there w	D PM, an interview was Director of Nursing (DON). expected the nurses to read nistration Record (MAR) and ed. The DON stated it was hat a medication was given , and she expected the Lasix vere no parameters to hold it, rould have been notified.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED		
		345184	B. WING _			C 08/03/2018	
	ROVIDER OR SUPPLIER	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	<b>.</b>	00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 759	Continued From pag	ge 57	F 7	59			
	4/23/17 and re-admidiagnoses including Fibrillation, Chronic Dysphagia and Gast Review of the Physic documented an order (Tylenol) Suppositor suppository rectally elevated temperatur Acetaminophen in 2.	Hypertension, Atrial Respiratory Failure, trostomy status.  cian's Order dated 1/29/18 er for Acetaminophen y 650 milligrams, insert 1 every 4 hours as needed for e; not to exceed 3 grams					
	Fahrenheit and pain  During an observation 8/1/18 at 12:40 PM of 650 milligrams of Act medication cup and entered Resident #7 gastrostomy tube (Ground for patency). The Ground country of the ground and the state of the ground and the state of the ground for patency of the ground for patency. The Ground for patency of the ground	on of a medication pass on with Nurse #1, she placed retaminophen into a crushed the medication. She is room. The resident's st) placement was checked was flushed with 120 cc of water. The Acetaminophen a GT.  reconciliation, it was nurse had documented as sistory 650 milligrams, insert 1 every 4 hours as needed for e.					
	_	with Nurse #1 on 8/1/18 at why she gave the Tylenol der was written for					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		345184	B. WING			1	C ( <b>03/2018</b>
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAR	E & REHAB-ELIZABETH CITY		9	STREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 759 F 761 SS=D	that?" She then state and get an order for Twas already a standir During an interview won 8/1/18 at 1:15 PM have administered the ordered, as a suppose During an interview was 8/03/18 at 10:40 AM should have been give documented it was git Label/Store Drugs and CFR(s): 483.45(g)(h) §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the capplicable.	d, "really, why would I do d she would delete that entry Tylenol per GT, unless there ng orders for this.  with the Director of Nursing she stated the nurse should e medication as it was itory.  with the Administrator on she stated the medication en as ordered and ven. d Biologicals (1)(2)  of Drugs and Biologicals s used in the facility must be e with currently accepted s, and include the y and cautionary		759 761	,		8/29/18
	Federal laws, the faci biologicals in locked of temperature controls, personnel to have acc §483.45(h)(2) The faci locked, permanently a storage of controlled the Comprehensive E	ordance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys.  cility must provide separately affixed compartments for drugs listed in Schedule II of Orug Abuse Prevention and nd other drugs subject to					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345184	B. WING		C 08/03/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/03/2010	
	==			901 SOUTH HALSTEAD BOULEVARD		
CONCOR	DIA TRANSITIONAL CAR	E & REHAB-ELIZABETH CITY		ELIZABETH CITY, NC 27909		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 761	Continued From page	÷ 59	F 76	1		
F 761	abuse, except when to package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on observation facility failed to dispose medications and suppredications carts revistorage.  The findings included  1. An inspection of the was conducted on 8/2 nurse standing beside bottle labeled as Vital expiration date 2/2013 Vitamin B 1 100 mg he 7/2018. A bottle labe 500 mg had a pharmate expiration date.  An interview was consimmediately following stated the Minimum Expiration date the Minimum Expiration to see The nurse tried to per was covering the expiration the suppression of the per was covering the expiration detected.	he facility uses single unit tition systems in which the imal and a missing dose can is not met as evidenced as and staff interviews, the se/discard out of date elements for 2 of 4 iewed for medication cart 1/2018 at 9:19 AM with the elements the medication cart. A min E 400 IU had as an 8. A bottle labeled as and as an expiration date of led as turmeric curcumin acy sticker over the ducted with Nurse # 8 the inspection. The nurse	F 76	1. All medication carts and medication room were checked for expired medications on 8/01/2018 by the Direct of Nursing and Unit Manager(s); no oth expired medications were found.  2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 on all medication carts, the medication room and the central supply room for expired medication.  3. The Staff Development Coordinator and/or Administrative Nurse re-educate all Licensed Nurses 8/24/2018 on checking medication expiration date ar removing expired medication from medication cart.  4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit all medication carts for expired medication 3 times a week for 1 month, then once	ed ed end	
	_	was unable to say what the		week for 2 months.	a	
	never checked the me	AM, an interview was DS nurse, who stated she edication carts for expired ght the nurse on the cart		5. Data results will be reviewed and analyzed at the center's monthly Quali Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction a	·	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		I DENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345184	B. WING _			C 08/03/2018	
	ROVIDER OR SUPPLIER	RE & REHAB-ELIZABETH CITY		90	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HALSTEAD BOULEVARD LIZABETH CITY, NC 27909	1 00/	03/2010
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 761	On 8/2/2018 at 3:04 conducted with the DThe DON stated the carts when she came check was on 7/25/20 expected the nurses removed expired med.  2. An inspection of the was conducted on 8/nurse standing besides as Rena-Vite supplered date 5/2018.  An interview was confirmediately following stated she was an account with the DThe DON stated the carts when she came check was on 7/25/20 expected the nurses removed expired med Resident Records - In CFR(s): 483.20(f)(5) Reside	PM, an interview was irector of Nursing (DON). Pharmacist checked the exto the facility and the last 1018. The DON stated she to check the cart and dications.  The 200-hall medication cart 1/2018 at 9:24 AM with the exto the cart. A bottle labeled ment had as an expiration and dication. The nurse gency nurse and was not exto cart for expired  PM, an interview was irector of Nursing (DON). Pharmacist checked the exto the facility and the last 1018. The DON stated she to check the cart and dications. Interview was dentifiable Information		761	needed.		8/29/18
	resident-identifiable t (ii) The facility may re resident-identifiable t	o the public. elease information that is					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
		345184	B. WING			1	C 03/2018
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAR	E & REHAB-ELIZABETH CITY		90	TREET ADDRESS, CITY, STATE, ZIP CODE D1 SOUTH HALSTEAD BOULEVARD LIZABETH CITY, NC 27909	1 00/	00/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 842			F	342			
		disclose the information ne facility itself is permitted					
	•	rdance with accepted is and practices, the facility al records on each resident ented; e; and					
	all information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, par operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purp purposes, research permedical examiners, for a serious threat to he by and in compliance §483.70(i)(3) The factorized section when the serious threat to he by and in compliance	r their resident permitted by applicable law; yment, or health care ted by and in compliance					
	§483.70(i)(4) Medical	records must be retained					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345184	B. WING			08/03/2018			
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CA	RE & REHAB-ELIZABETH CITY		90	REET ADDRESS, CITY, STATE, ZIP CODE  1 SOUTH HALSTEAD BOULEVARD  LIZABETH CITY, NC 27909				
(X4) ID PREFIX TAG			ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 842	(ii) Five years from the there is no requirem (iii) For a minor, 3 years legal age under State \$483.70(i)(5) The moderate (i) Sufficient information (ii) A record of the results of around resident review determinations condition (v) Physician's, nursiprofessional's progressional's progressional's progressional's progressional's progressional resident and staff introduced in the electronic Mercord for 3 of 3 resident and staff introduced in the electronic mercord for 3 of 3 resident and staff introduced in the electronic mercord for 3 of 3 resident observed for splint (Resident #33). The findings include 1. Resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017, with diagnostic for a minor resident #35 was 6/9/2017.	e required by State law; or he date of discharge when ent in State law; or ears after a resident reaches e law.  edical record must containtion to identify the resident; esident's assessments; sive plan of care and services by preadmission screening evaluations and ucted by the State; e's, and other licensed ess notes; and ology and other diagnostic required under §483.50.  T is not met as evidenced ons, record review and erviews, the facility staff ented medications, nutritional otein supplements as given dication Administration sidents who were observed pass (Resident #33, #35, and staff inaccurately documented eatment Administration on of a hand splint for 1 of 1 or the application of hand b.	F	342	1. Proper documentation updated on 7/31/2018 for enteral feedings given, splint placement, and medications on hold.  2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 with current resident population who receive eterna nutrition, splint application, and physici made aware if any medication were he 3. The Staff Development Coordinator and/or Administrative re-educated all Licensed Nurses 8/24/2018 on recordicorrect documentation on eternal feediamounts, splints, and medications beir	ian eld. ng ing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345184	B. WING _			08/	) 03/2018
NAME OF P	ROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE			00.20.10
0011000	014 TD 4 NOITION 41 04 D			901 SOUTH HALSTEAD BOULEVARD			
CONCOR	JIA TRANSITIONAL CAR	E & REHAB-ELIZABETH CITY		ELIZABETH CITY, NC 27909			
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 842	Continued From page	e 63	F 8	42			
	6/15/2018 revealed he impaired.	er cognition was moderately		held. Staff not available for trainidate will be educated before nex	kt worki		
	Physician orders date the following:	ed 7/2018 included as orders		shift. The Director of Nursing an Interdisciplinary Team will review documentation in Clinical Mornir meeting to ensure ongoing com	v ng		
	(mg) 2 times per day, pressure (SBP) less t press (DBP) less than than 65.	ension) 12.5 milligrams hold for a systolic blood han 110, diastolic blood n 75, heart rate (HR) less ertension) 5 mg tablet 1 time		4. The Director of Nursing, Staff Development Coordinator, and/o Administrative Nurse will audit a Licensed Nurses on accurate documentation with eternal nutri splints, and Medical Doctor mad	or II tion, le aware	e	
	than 75, HR less than	less than 110, DBP less 65. ng one time per day related		of medication being held and the 3 times a week for 1 month, ther a week for 2 months. The Direc Nursing, Staff Development Coc and/or Administrative Nurse will	n 2 time tor of ordinato	es or,	
	-	topical anti-inflammatory) s transdermally 4 times a		accurate documentation is computation during audits.  5. Data results will be reviewed analyzed at the center's monthly	and	v.	
		pplement) 120 milliliters (ml) edication pass, document d.		Assurance and Performance Improvement meeting for three r with a subsequent Plan of Corre needed.	months		
	Protein modular powo supplement.	der two times per day for					
	medication administra was observed for Res stated Resident #35's and she was to hold t Norvasc 5mg tablets	46 AM until 8:55 AM, a ation pass with Nurse #5 sident #35. The nurse blood pressure was 103/62 he Coreg 12.5 mg and for a blood pressure of less se readied and dispensed 8 Resident #35.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345184	B. WING				03/2018
NAME OF PROVIDER OR SUPPLIER  CONCORDIA TRANSITIONAL CARE & REHAB-ELIZABETH CITY				STREET ADDRESS, CI 901 SOUTH HALSTE ELIZABETH CITY,	AD BOULEVARD	1 00/	03/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD E FERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	During the medication given are compared to discovered that the number of the discovered during the number of the numb	n reconciliation (medications o what was ordered) it was urse had documented she asix 20 mg at 8:47 AM on itritional supplement at 8:46 onsumed, Protein powder at onsumed, and Diclofenac	F	42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345184	B. WING		C 08/03/2018		
NAME OF PROVIDER OR SUPPLIER  CONCORDIA TRANSITIONAL CAR			STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	00/03/2010		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
4/23/17 and re-admit diagnoses including Fibrillation, Chronic F Dysphagia and Gastin Review of the electron Administration record documented an orde (Tylenol) Suppository suppository rectally elevated temperature Acetaminophen in 24 During an observation Resident #7 on 8/1/1 with an axillary temperature Fahrenheit.  During an observation 8/1/18 at 12:40 PM, I milligrams of Acetamicup and crushed the Resident #7's room. The GT was flushed centimeters) of water administered into the observed to sign the order as given in the During an interview with 1:00 pm, when asked per GT when the ord suppository, she stat that?" She then state and get an order for	admitted to the facility on ted on 1/29/18 with Hypertension, Atrial Respiratory Failure, rostomy status.  Inic Medication (MAR) for August 2018 of for Acetaminophen (MAR) o	F 84	2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345184	B. WING _			08/03/2018	
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAI	RE & REHAB-ELIZABETH CITY		901	REET ADDRESS, CITY, STATE, ZIP CODE  SOUTH HALSTEAD BOULEVARD  IZABETH CITY, NC 27909	1 00/	03/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 842	have administered the ordered, as a suppose have deleted the ent Administration Record During an interview was 8/03/18 at 10:40 AM should have been give documented it was good 3. Resident #33 was 3/10/15 with diagnose Mellitus, Chronic Isol Hemiplegia and Hemicerebrovascular Accord Review of the Physic documented an ordes supplement, one con 8AM, 12PM and 4PM Review of the Care F 10/11/17, revealed Review of the Care F 10/11/17, revealed Review of the most replaced by the most replaced b	I she stated the nurse should be medication as it was sitory. The nurse should not ry on the Medication rd.  With the Administrator on she stated the medication wen as ordered and iven.  admitted to the facility on es including Diabetes nemic Heart disease, hiparesis following a cident and Dementia.  Stan's Order dated 10/18/16 or for a Glucose control stainer three times per day at M.	F	342			
	order for a Glucose (	Control supplement, one sa day and was documented					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				ATE SURVEY DMPLETED
		345184	B. WING _				C 08/03/2018
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CA	RE & REHAB-ELIZABETH CITY		901 SOUTH H	ESS, CITY, STATE, ZIP CODE ALSTEAD BOULEVARD CITY, NC 27909		50/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE EACH CORRECTIVE ACTION SHO OSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 842	Continued From pag	ge 67 /18 at 1:03 PM of lunch did	F 8	342			
		ement on the resident's					
	9:07 AM she stated Glucose Control sup she did not know wh	with Nurse #1 on 8/1/18 at the resident received a oplement three times daily but no was responsible for giving and stated it must come from					
	1 on 8/1/18 at 9:10 A did not have a suppl	with Nursing Assistant (NA) # AM she stated the resident ement on his meal tray and se gave the supplement to the					
	8/02/18 at 9:22 AM s responsible for provi	with the Dietary Manager on she stated dietary was not iding supplements on the ing provided supplements.					
	on 8/2/18 at 9:49 AM	with the Registered Dietician  If she stated Resident #33  pplements with med pass.					
	on 8/2/18 at 10:01 A were given by the numedication cart. The give the supplement	with the Director of Nursing M she stated all supplements urses and were on the e nurses were expected to s and chart as such. If the en the nurse should not chart					
	8/02/18 at 10:15 AM documented the Glu given on the MAR be	cose Control supplement as					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345184	B. WING		,	C 98/03/2018	
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL C	ARE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909		0.00.20.10	
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	supplements. She today that nurses we the supplements. Since the supplements. Since the supplement.  During a follow up Dietician on 8/02/14 about six months at the glucose control was receiving. She this was not address the resident probability supplement since the supplement since the supplement sabout changed on the MADUring an interview 8/02/18 at 2:14 PM supplements about changed on the MADUring an interview 8/3/18 at 10:40 AM should have been supplements about changed on the MADURING SITE SITE SITE SITE SITE SITE SITE SITE	aned he received the stated she was informed were responsible for providing the stated she went to get the opplement from the supply y doesn't even have this type interview with the Registered 8 at 10:35 AM she stated that go the facility stopped carrying supplement that the resident stated she did not know why seed on any notes and stated oly had not received the he facility did not carry that any with the Nurse Consultant on he stated the facility switched 6 months ago and it was not AR.	F 8	42			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345184	B. WING _			1	C 03/2018
	ROVIDER OR SUPPLIER	RE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909			03/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	as ordered.  Review of the Care A 3/16/18 documented Activities of Daily Liv had contractures.  Review of the Physic read Resident #33 w Occupational Therap was to receive passi to the left shoulder, or prior to putting on a support.  Review of the most in Data Set (MDS) Assidentified Resident # impaired with a Brief score of 8 (on a scal cognitively intact). H  Observations of Res AM revealed he was lunch. He was obseleft hand and there we place.  Observations on 7/3 Resident #33 in his was splint in place.	Area Assessment dated Resident #33 required ing (ADL) assistance and cian's Order dated 4/3/18	F	342			
	Resident #33 in bed	/18 at 7:51 AM revealed with no hand splint in place. /18 at 11:28 AM revealed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			SURVEY
		345184	B. WING _			C 03/2018	
	ROVIDER OR SUPPLIER  DIA TRANSITIONAL CAF	RE & REHAB-ELIZABETH CITY		9	TREET ADDRESS, CITY, STATE, ZIP CODE  01 SOUTH HALSTEAD BOULEVARD  ELIZABETH CITY, NC 27909	1 00/	03/2010
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	During an interview of NA #1 she stated the splits. She further state hand at all.  During an interview of Therapist (O.T.) on 8 stated Resident #33 and in March 2018 a stated she worked for with the resident doin and using the hand sthe end of two weeks the nursing assistant when to use it. She strestorative program at the nursing assistant the passive range of splint. She stated she top dresser drawer. Resident #33's room. The O.T. pulled the strestorative program at the resident #33's room. The O.T. pulled the strestorative program at the passive range of splint. She stated she top dresser drawer. Resident #33's room. The O.T. pulled the strestorative program at the resident #33 stated, "at the resident's left eskin". She attempted the muscle was tight, an evaluation and mosplint on the left elbor further contracture. Si	18 at 8:06 AM revealed with no hand splint in place.  In 8/01/18 at 9:08 AM with resident did not wear wrist ted he could not use his left with the Occupational /02/18 at 8:42 AM she had always had a hand splint new one was ordered. She rapproximately two weeks ag passive range of motion plint. She further stated at she informed the nurse and of the splint and how and stated there was no at the facility and this meant is were responsible for doing motion and applying the enhad placed the splint in the The O.T. walked down to NA#3 was in the room. plint out of the top dresser the NA#3 how it was to be Ok." The O.T. then looked elbow and stated "I smell to move the left elbow and She stated she would do set likely place an elbow we to keep the elbow from the stated it was very ROM exercises to keep the	F	342			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY	
		345184	B. WING _				C 03/2018
	ROVIDER OR SUPPLIER	RE & REHAB-ELIZABETH CITY		9	STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	, 30.	30/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	e 71	F 8	842			
	_	on 8/02/18 at 1:32 PM with ed he had not had a splint on					
		vith NA #3 on 8/02/18 at 1:32 id not have the resident on A #2 had him.					
	8/02/18 at 1:34 PM s	terview with NA #3 on he stated she had worked ore and there had never boom.					
	PM she stated she ha	vith NA #2 on 8/02/18 at 1:34 ad not worked with the v and had no idea he was to					
	8/02/18 at 2:14 PM h on the Medication Ad	vith the Nurse Consultant on e stated the splint did not get Iministration Record because wrong so it never showed up					
	Director of Nursing s splint was not transfe Medication Administr the Kardex. She state from the care plan ar could see this in poin nursing station, on th hand-held device. Sh should have been in	on 8/2/17 at 2:48 PM with the the stated the order for the erred correctly to the ation Record but it was on the erred the Kardex was created and the nursing assistants at of care, either at the e wall station or their the stated the hand splint place as ordered and the en documented as done if					
F 880 SS=D	Infection Prevention CFR(s): 483.80(a)(1)		F 8	880			8/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED	
		345184	B. WING _	B. WING		C 08/03/2018	
NAME OF PROVIDER OR SUPPLIER  CONCORDIA TRANSITIONAL CARE & REHAB-ELIZABETH CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909	•	33.33.23.13	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 880	Continued From pag	ge 72	F8	80			
	§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		ATE SURVEY DMPLETED
		345184	B. WING _			C 08/03/2018
	ROVIDER OR SUPPLIER	ARE & REHAB-ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIF 901 SOUTH HALSTEAD BOULEVA ELIZABETH CITY, NC 27909	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE
F 880	depending upon the involved, and (B) A requirement the least restrictive possicircumstances. (v) The circumstance must prohibit emploid disease or infected contact with resident contact will transmit (vi)The hand hygient by staff involved in contact will transmit (vi)The hand hygient by staff involved in contact will transmit (vi)The hand hygient by staff involved in contact will transmit (vi)The hand hygient by staff involved in contact will transmit (vi)The hand hygient by staff involved in contact will transmit the corrective actions to staff involved in contact will be staff in the facility will contact in the facility will contact interviews, the facility will contact interviews, the facility in the facility will contact interviews, the facility in the facility will contact with the facility will contact with residual transmit and the facility will contact with resident to the facility will contact with reside	ration of the isolation, and the isolation should be the sible for the resident under the resident food, if direct resident food, if direct resident contact.  The disease; and reprocedures to be followed direct resident contact.  The for recording incidents facility's IPCP and the resident by the facility.  The recording incidents resident the resident of recording incidents resident to the resident contact.  The recording incidents resident the resident of recording incidents resident the recording incidents resident the recording incidents resident the recording incidents recording incid	F	1. All blood glucose mad disinfected by Staff Deve	chines were	
	sugars for 2 of 2 res resident #78) obser The findings include The facility's policy	fter use to check blood sidents (resident #45, and wed for blood sugar checks.		2. The Director of Nursing Development Coordinato Administrative Nurse per one-time audit 8/17/2018 of all Licensed Nurses for machines disinfecting propolicy and procedure.	g, Staff r, and/or formed a on competency r blood glucose	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345184	B. WING _			08	C 8/ <b>03/2018</b>
NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE	, ,	5,00,2010
CONCORDIA TRANSITIONAL CARE & REHAB-ELIZABETH CITY					1 SOUTH HALSTEAD BOULEVARD		
				El	LIZABETH CITY, NC 27909		
(X4) ID PREFIX TAG			ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	10/30/17 read: "Step 9: Wipe the entire surface of the meter 3 times horizontally and 3 times vertically to remove blood-borne pathogens. Step 10: Dispose of the used towelette in a trash bin.		F 8	380	3. The Staff Development Coordinator and/or Administrative Nurse re-educated all Licensed Nurses 8/24/2018 on disinfecting glucometers per policy and procedure. Staff not available for training by set date will be educated before next working shift. The Director of Nursing and Interdisciplinary Team will review audits in		
	Step 11: allow exterior appropriate contact to using a dry cloth."  Glucometers manufacture appropriate contact to using a dry cloth."						
	for cleaning and disin the facility used one of disinfectant cloths. T read: "Step 8: Allow 6			Clinical Morning meeting to ensure ongoing compliance.  4. The Director of Nursing, Staff			
	meter using a dry clot recommended wipe in	ct time and then wipe the th." The manufacturer nstructions were visible on follows: "Allow treated			Development Coordinator, and/or Administrative Nurse will observe all Licensed Nurses on proper cleaning of glucometers 3 times a week for 1 month		
	surface to remain we air dry." The non-rec germicidal/disinfectar	t for a full two minutes. Let ommended nt wipe instructions were			then 2 times a week for 2 months.  5. Data results will be reviewed and		
	surface must remain minutes. Use additio	ontainer as follows: "Treated visibly wet for a full 4 nal wipe(s) if needed to minutes wet contact time."			analyzed at the center's monthly Qualitassurance and Performance Improvement meeting for three months with a subsequent Plan of Correction a	;	
		lood sugar check was			needed.	.5	
	#6, and Nurse #7, for gathered supplies and The Nurse wiped the	18 at 10:59 AM with Nurse Resident # 45. Nurse #6 d put them in a plastic cup. glucometer for 10 seconds					
	and threw the wipe av "according to the instruction container, we have to for 4 minutes." The g cup. At 11:11 the nur was dry, but stated the	non-recommended wipes, way. Nurse #7 stated, ructions on the wipe be let the glucometer air dry glucometer was placed in a rses agreed the glucometer riey needed to wait the 4 could use it. The blood					
sugar was obtained		y Nurse #6, and then she					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345184	B. WING _		0.9	C 08/03/2018	
NAME OF PROVIDER OR SUPPLIER  CONCORDIA TRANSITIONAL CARE & REHAB-ELIZABETH CITY				STREET ADDRESS, CITY, STATE, ZIP O 901 SOUTH HALSTEAD BOULEVAR ELIZABETH CITY, NC 27909	CODE	103/2016	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		DATE	
F 880	disinfectant wipe at glucometer in a cup made of Nurse #7 to wipe container, to w visibly wet for 4 miniglucometer was not nurses could not dedisinfected or not.  A second observation conducted on 8/1/20 #1 for the Resident in needed to clean her glucometer for 10 sewipe, and then folded glucometer on the wiped and swiped and glucometer 2 times in medication cart and nurse stated the residid not have needlest the glucometer in thinget a needle.  On 8/1/2018 at 12:0 conducted with Nurse cleaned the glucometer.  On 8/1/2018 at 12:2 conducted with the Standard wet for 2 representation of the second with the Standard wit	er for 10 seconds with a 11:18 AM. The nurse set the to air dry. A request was a read the instructions on the hich she replied the label said utes. The nurse stated the wet for 4 minutes. The cide if the glucometer was an of a blood sugar check was an at 11:56 AM with Nurse #78. The nurse stated she machine and wiped the econds with a recommended at the wipe and set the ripe. The nurse obtained the nused the same folded cross the top of the and set the glucometer on the threw the wipe away. The ident needed insulin and she is on her cart, so she dropped is medication cart and left to 8 PM, an interview was set #1. The nurse stated she eter before and after the put the glucometer had not minutes as indicated on the	F 8	380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
345184			B. WING			C	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COL 901 SOUTH HALSTEAD BOULEVARD		8/03/2018	
CONCORDIA TRANSITIONAL CARE & REHAB-ELIZABETH CITY				ELIZABETH CITY, NC 27909			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG				
F 880	isolation.  On 8/2/2018 at 2:52 F conducted with the D The DON stated her cleaning was the 2-m for 2 minutes and the used for 4 minutes fo	PM, an interview was irector of Nursing (DON). expectations for glucometer inute wipes should be used 4 minutes wipes should be	F	380			