STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification with complaint survery was conducted from 6/24/19 to 6/27/19. 1 of 4 allegations was substantiated which resulted in deficiency F695. The facility was found in compliance with CFR 483.73 Emergency Preparedness. Event ID #GDG011.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565		7/23/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 1 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with residents and staff, the facility failed to resolve repeat concerns with food palatability reported during Resident Council meetings for 2 consecutive months. The findings included: Review of the monthly Resident Council meeting minutes dated 4/3/19 included, in part, concerns related to bread being "soggy". The minutes indicated, "the covers that are placed on the plates were causing the bread to become soggy due to steam being trapped in the plate". The Dietary Manager (DM) was present at the meeting and stated that she was going to work on getting bags for the bread to resolve the issue. These minutes were recorded by the Activities Director. Review of the monthly Resident Council meeting minutes dated 5/2/19 included, in part, the repeat concern of bread and rolls still being "soggy". The meetings indicated that the residents were assured the DM was working on getting bread bags. These minutes were recorded by the Activities Director. A Resident Council meeting was conducted on 6/25/19 at 3:00 PM with 10 alert and oriented residents who were active participants in the	F 565	Preparation and submission of this plan of correction by Wadesboro Health and Rehabilitation, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. F565 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1a. Current residents that participate in Resident Council will be notified of the new process of keeping bread from becoming damp. 2. Address how corrective action will be accomplished for those resident's having potential to be affected by the same deficient practice: 2a. Current residents that receive bread will be served in a clear plastic flip bag at each meal to prevent dampness to bread when placed on tray.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 2 facility's Resident Council. The residents reported that they had a repeat concern related to bread and rolls being soggy when served at lunch and dinner. The meeting attendees all stated that they had discussed this issue with the DM during a Resident Council meeting a couple of months ago and that she stated she would get bags for the bread to eliminate the issue of the bread becoming soggy. The residents reported that this concern had not yet been resolved and that their bread and rolls continued to be soggy when served to them. An interview was conducted with the DM on 6/26/19 at 8:45 AM. She confirmed she had attended a few of the Resident Council meetings and that she was aware of the repeat concern voiced by the residents related to bread and rolls being soggy when served. She stated that she had informed the residents she would obtain bread bags to eliminate the issue of soggy bread. The DM explained that if the bread and/or rolls were placed in a bag that it would prevent steam from getting into the bread product causing it to become soggy. She reported that after she was first informed about the concern a couple of months ago that she contacted her representative from the food company to see if she could order the bread bags. She stated that she had not received approval at that time and she had forgotten to follow up on this issue. An interview was conducted with the Activities Director on 6/26/19 at 9:00 AM. She confirmed she was aware that the Resident Council had a repeat concern related to bread and rolls being soggy when served. She stated that the DM was aware of the issue as she was in attendance at the meeting when this was first discussed	F 565	3. Address what measures will be put into place, or systemic changes to ensure that the deficient practice will not occur: 3a. Administrator will educate the Dietary Director, Activities Director and Social Worker on importance of how to complete and follow-up on grievances/concerns discussed in Resident Council. 3b. Resident Council meeting minutes have been reviewed for last 3 months by the Administrator to ensure all grievances and/or concerns have been addressed from Resident Council meeting. 3c. Activities Director and/or Social Worker will ask during Resident Council meeting for the next 3 months about the bread being served and is it without dampness. Any grievances/concerns will be reported to the Administrator. 3d. Administrator will review the Resident Council Meeting minutes and the concern forms generated from them with the Activities Director and Social Worker after each meeting. 3e. Concerns will be logged in the grievance/concern log for noting in trending. 4. Indicate how the facility plans to monitor its performance to make sure the solutions(s) are sustained: 4a. Administrator and/or designee(s) will review all grievances/concerns 5x/week x 4 weeks; then 3x/week x 4 weeks and weekly x 4 weeks to ensure that all grievances/concerns have been addressed and completed timely. Results of all audits will be reviewed monthly x 3 months by the QAPI Committee. If any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 3 (4/3/19). The Activities Director reported that her responsibility was to ensure the department heads were aware of any concerns reported at the meetings for their departments, and that it was out of her hands from there. An interview was conducted with the Director of Nursing on 6/27/19 at 10:40 AM. She indicated she expected Resident Council repeat concerns to be addressed.	F 565	discrepancies are noted, further action will be implemented. 5. Completion Date 7/23/2019	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medications (Residents #1, #8, #12, and #57), active diagnosis (Resident #8), and alarms (Resident #57) for 4 of 6 residents whose medications were reviewed. The findings included: 1. Resident #8 was admitted to the facility on 5/23/17 with diagnoses that included anxiety disorder, schizophrenia, psychosis, and epilepsy. 1a. A review of Resident #8 ' s physician ' s order summary for April 2019 included Buspar (antianxiety medication) 5 milligrams (mg) in the morning, Buspar 10 mg twice daily, and Ativan (antianxiety medication) 0.5 mg every 12 hours. The April 2019 physician ' s order summary	F 641	F641 1. Address how corrective action will be accomplished for those residents' found to have been affected by the deficient practice: 1a. Resident #1 - Minimum Data Set (MDS)for hypnotic use was removed and completed and care plan updated. Resident #8 - Active Diagnosis was removed and completed. Resident #8 - MDS for hypnotic use and Gradual Dose Reduction (GDR) contraindications was corrected and resubmitted; Care plan was corrected and updated. Resident #12 - MDS for hypnotic use was removed and completed and care plan updated. Resident #57 - MDS for hypnotic use and wander guard was corrected and resubmitted and care plan updated.	7/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 4 included no hypnotic medications for Resident #8. A review of the Medication Administration Record (MAR) for Resident #8 from 4/6/19 through 4/12/19 indicated Resident #8 was administered Buspar and Ativan on 7 of 7 days and no hypnotic medications. The quarterly Minimum Data Set (MDS) assessment dated 4/12/19 indicated Resident #8 ' s cognition was severely impaired. She was coded with antianxiety medication and hypnotic medication on 7 of 7 days. The medications section of Resident #8 ' s 4/12/19 MDS was coded by MDS Nurse #1. An interview was conducted with MDS Nurse #1 on 6/27/19 at 9:30 AM. The medications section of Resident #8 ' s 4/12/19 MDS that indicated she received hypnotic medication on 7 of 7 days was reviewed with MDS Nurse #1. The April physician ' s order summary and MAR that indicated Resident #8 had received no hypnotic medication was reviewed with MDS Nurse #1. MDS Nurse #1 stated that she coded this MDS assessment for 7 of 7 hypnotics based on Resident #8 ' s receipt of Buspar and Ativan. She revealed that she had been completing MDS assessments for over 2 decades and that she had always coded the antianxiety medications of Buspar and Ativan as both antianxiety medications and hypnotic medications on the MDS. An interview was conducted with the Director of Nursing on 6/27/19 at 10:30 AM. She indicated that she expected the MDS to be coded accurately.	F 641	2. Address how corrective action will be accomplished for those residents having the potential to be affected by the deficient practice: 2a. 100% audit was completed on all MDS's for the residents' in the last 30 days, currently in facility, for accuracy of assessments in regards to coding for hypnotic use, appropriate diagnosis, GDR's, and coding of wander guards if utilized for any resident(s). 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: 3a. Education to the MDS Nurses was conducted by the Regional Director of Clinical Services (RDCS)on accuracy of coding residents appropriately to reflect the resident's status to include coding MDS for the indicated use and/or classification of medication, coding of residents' with wander guards and have corrective care plans to reflect the resident's care. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: 4a. Administrator and/or Director of Nursing (DON) will review MDS calendar and complete audit weekly x 12 weeks them monthly x 12 months. Results of the audit will be reviewed monthly for 3 months by the QAPI Committee. If any discrepancies are noted, further action will be implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5 1b. A physician ' s order for Resident #8 dated 5/16/18 indicated Geodon (antipsychotic medication) 60 milligrams (mg) in the morning. A physician ' s order for Resident #8 dated 1/23/19 indicated Geodon 40 mg at bedtime. A Psychiatric Nurse Practitioner (PNP) note dated 3/27/19 indicated that Resident #8 continued on Geodon 60 mg in the morning and 40 mg at bed. This note indicated that a dose reduction attempt was clinically contraindicated for Resident #8. The quarterly Minimum Data Set (MDS) assessment dated 4/12/19 indicated Resident #8 ' s cognition was severely impaired. She was coded with antipsychotic medication on 7 of 7 days, routine usage of antipsychotics only, and the last attempted Gradual Dose Reduction (GDR) date was 4/10/18. This assessment also indicated that there was no physician documentation that a GDR was clinically contraindicated for Resident #8. The medications section of Resident #8 ' s 4/12/19 MDS was coded by MDS Nurse #1. An interview was conducted with MDS Nurse #1 on 6/27/19 at 9:30 AM. The medications section of Resident #8 ' s 4/12/19 MDS that indicated there was no physician documentation that a GDR was clinically contraindicated for Resident #8 was reviewed with MDS Nurse #1. The 3/27/19 PNP note that indicated a GDR was clinically contraindicated was reviewed with MDS Nurse #1. MDS Nurse #1 stated that she reviewed physician ' s note, Nurse Practitioner notes, and PNP notes to code this section of the MDS related to antipsychotic medication GDRs. She was unable to explain why this MDS was	F 641	5. Date of Compliance: 07/23/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 6	F 641		

coded to indicate that there was no physician documentation that a GDR was clinically contraindicated.

An interview was conducted with the Director of Nursing on 6/27/19 at 10:30 AM. She indicated that she expected the MDS to be coded accurately.

1c. Resident #8 ' s care plan included, in part, the focus area of the potential for seizures related to a diagnosis of epilepsy. This focus area was initiated on 8/29/17. The goal indicated that Resident #8 would be free from seizure activity in the next 90 day review period. The interventions for this focus area included, in part, administer medications as ordered, observe for tolerance, effectiveness, possible adverse side effects, and notify physician/Nurse Practitioner (NP) as indicated; observe for changes in neuro status and report to physician/NP any changes; and obtain laboratory results as ordered, report and review results with physician/NP.

An NP note dated 2/20/19 indicated that Resident #8 ' s diagnosis and assessment included, in part, epilepsy and recurrent seizures.

The quarterly Minimum Data Set (MDS) assessment dated 4/12/19 indicated Resident #8 ' s cognition was severely impaired. Resident #8 was not coded with an active diagnosis of epilepsy/seizure disorder. The active diagnoses section of Resident #8 ' s 4/12/19 MDS was coded by MDS Nurse #1.

An interview was conducted with MDS Nurse #1 on 6/27/19 at 9:30 AM. The active diagnoses section of Resident #8 ' s 4/12/19 MDS that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 7	F 641		

indicated no active diagnosis of epilepsy/seizure disorder was reviewed with MDS Nurse #1. The care plan that indicated the focus area of the potential for seizures related to a diagnosis of epilepsy that was an active care plan during the review period of the 4/12/19 MDS was reviewed with MDS Nurse #1. The NP note dated 2/20/19 that indicated epilepsy and recurrent seizures was an active diagnosis for Resident #8 was reviewed with MDS Nurse #1. MDS Nurse #1 stated that she had not coded Resident #8 with an active diagnosis of epilepsy on the 4/12/19 MDS as the resident had no seizures and no seizure medication administered during the 7-day review period of the 4/12/19 MDS. She indicated she had not viewed the care plan related to the potential for seizures as having a direct relationship to Resident #8 ' s status at the time of the 4/12/19 MDS.

An interview was conducted with the Director of Nursing on 6/27/19 at 10:30 AM. She indicated that she expected the MDS to be coded accurately.

2. Resident #57 was most recently admitted to the facility on 5/14/18 with diagnoses that included Alzheimer ' s disease, dementia, and anxiety disorder.

2a. A physician ' s order for Resident #57 dated 6/18/18 indicated Buspar (antianxiety medication) 5 milligrams (mg) three times daily.

A review of Resident #57 ' s physician ' s order summary for September 2018 included Buspar 5 mg three times daily. The September 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 8	F 641		

physician ' s order summary included no hypnotic medications for Resident #57.

A review of the Medication Administration Record (MAR) for Resident #57 from 9/22/18 through 9/28/19 indicated she was administered Buspar on 7 of 7 days and no hypnotic medications.

The quarterly Minimum Data Set (MDS) assessment dated 9/28/18 indicated Resident 57 ' s cognition was severely impaired. She was coded with antianxiety medication and hypnotic medication on 7 of 7 days. The medications section of Resident #57 ' s 9/28/18 MDS was coded by MDS Nurse #2.

An interview was conducted with MDS Nurse #2 on 6/27/19 at 9:30 AM. The medications section of Resident #57 ' s 9/28/18 MDS that indicated she received hypnotic medication on 7 of 7 days was reviewed with MDS Nurse #2. The September 2018 physician ' s order summary and MAR that indicated Resident #57 had received no hypnotic medication was reviewed with MDS Nurse #2. MDS Nurse #2 stated that she coded this MDS assessment for 7 of 7 hypnotics based on Resident #8 ' s receipt of Buspar. She revealed that she had been trained to code the antianxiety medication Buspar as both an antianxiety medication and hypnotic medication on the MDS.

An interview was conducted with the Director of Nursing on 6/27/19 at 10:30 AM. She indicated that she expected the MDS to be coded accurately.

2b. A physician ' s order dated 5/22/18 indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 9	F 641		

a wander/elopement alarm was in place for Resident #57.

A review of the Medication Administration Record (MAR) for Resident #57 from 9/22/18 through 9/28/18 indicated a wander/elopement alarm was in place daily.

The quarterly Minimum Data Set (MDS) assessment dated 9/28/18 indicated Resident 57 ' s cognition was severely impaired. Resident #57 was coded by MDS Nurse #2 with no wander/elopement alarm.

An interview was conducted with MDS Nurse #2 on 6/25/19 at 4:25 PM. The 9/28/18 MDS for Resident #57 that indicated she had no wander/elopement alarm was reviewed with MDS Nurse #2. The September 2018 MAR that indicated a wander/elopement alarm was in place daily for Resident #57 was reviewed with MDS Nurse #2. She revealed this was an oversight and she was going to modify the MDS.

An interview was conducted with the Director of Nursing on 6/27/19 at 10:30 AM. She indicated that she expected the MDS to be coded accurately.

3. Resident #12 was most recently readmitted to the facility on 10/24/18 with diagnoses that included anxiety disorder.

A physician ' s order for Resident #12 dated 11/12/18 indicated Buspar (antianxiety medication) 10 milligrams (mg) three times daily.

A review of Resident #12 ' s physician ' s order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 10	F 641		

summary for April 2019 included Buspar 10 mg three times daily. The April 2019 physician ' s order summary included no hypnotic medications for Resident #12.

A review of the Medication Administration Record (MAR) for Resident #12 from 4/13/19 through 4/19/19 indicated he was administered Buspar on 7 of 7 days and no hypnotic medications.

The quarterly Minimum Data Set (MDS) assessment dated 4/19/19 indicated Resident 12 ' s cognition was intact. He was coded with antianxiety medication and hypnotic medication on 7 of 7 days. The medications section of Resident #12 ' s 4/19/19 MDS was coded by MDS Nurse #1.

An interview was conducted with MDS Nurse #1 on 6/27/19 at 9:30 AM. The medications section of Resident #12 ' s 4/19/19 MDS that indicated he received hypnotic medication on 7 of 7 days was reviewed with MDS Nurse #1. The April physician ' s order summary and MAR that indicated Resident #12 had received no hypnotic medication was reviewed with MDS Nurse #1. MDS Nurse #1 stated that she coded this MDS assessment for 7 of 7 hypnotics based on Resident #12 ' s receipt of Buspar. She revealed that she had been completing MDS assessments for over 2 decades and that she had always coded the antianxiety medication Buspar as both an antianxiety medication and hypnotic medication on the MDS.

An interview was conducted with the Director of Nursing on 6/27/19 at 10:30 AM. She indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 11	F 641		

that she expected the MDS to be coded accurately.
4.
Resident #1 was admitted to the facility on 2/9/18 with the diagnosis of Alzheimer ' s Dementia.

A review of Resident #1 ' s care plan dated 3/22/19 and updated 4/11/19 revealed goals and interventions for confusion, memory deficit, and psychotropic medication.

A review of the Medication Administration Record (MAR) for Resident #1 from 6/7/19 through 6/14/19 indicated Resident #1 was administered Ativan on 7 of 7 days and no hypnotic medications.

A review of Resident #1 ' s quarterly Minimum Data Set (MDS) dated 6/14/19 revealed the resident had highly impaired vision and hearing and a severely impaired cognition. The resident had psychosis and no behaviors. The resident required extensive assistance for her activities of daily living. The active diagnoses were psychotic disorder and dementia. The resident received for 7 days an anti-psychotic, anti-anxiety, and hypnotic.

An interview was conducted with MDS Nurse #1 on 6/27/19 at 9:30 AM. The medications section of Resident #1 ' s 6/14/19 MDS that indicated she received hypnotic medication on 7 of 7 days was reviewed with MDS Nurse #1. The June 2019 physician ' s order summary and MAR that indicated Resident #8 had received no hypnotic medication was reviewed with MDS Nurse #1. MDS Nurse #1 stated that she coded this MDS assessment for 7 of 7 hypnotics based on Resident #1 ' s receipt of Ativan. MDS Nurse #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 12 revealed that she had been completing MDS assessments for over 2 decades and that she had always coded Ativan, antianxiety medication as both antianxiety medication and hypnotic medication on the MDS. An interview was conducted with the Director of Nursing on 6/27/19 at 10:30 AM. She indicated that she expected the MDS to be coded accurately for medication.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and 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 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		7/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 13 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop comprehensive, person-centered, and individualized care plans in the areas of psychotropic medications (Residents #8, #12, and #20), and diagnoses (Resident #45) for 4 of 15 residents reviewed. The findings included: 1. Resident #8 was admitted to the facility on 5/23/17 with diagnoses that included anxiety disorder, schizophrenia, and psychosis. A review of Resident #8 ' s April 2019 physician ' s order summary included the psychotropic medications Geodon (antipsychotic medication), Ativan (antianxiety medication), Buspar (antianxiety medication), and Trazodone (antidepressant medication). Resident #8 had no physician ' s orders for hypnotic medication. The quarterly Minimum Data Set (MDS)	F 656	F656 1. Address how corrective action will be accomplished for those residents' found to have been affected by the deficient practice: 1a. Care plans have been corrected in the area of psychotropic medications for residents #8, #12, and #20; and area of diagnosis for resident #45. 2. Address how corrective action will be accomplished for those residents having the potential to be affected by the deficient practice: 2a. A 30 day audit of all residents on the care plan schedule in the areas of psychotropic medications and active diagnosis was conducted by the Regional Reimbursement Specialist and the Director of Nursing. All deficient areas identified were corrected by the MDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 14 assessment dated 4/12/19 indicated Resident #8 ' s cognition was severely impaired. She was coded by MDS Nurse #1 with 7 of 7 antianxiety medication, antidepressant medication, antipsychotic medication, and hypnotic medication. A review of Resident #8 ' s active physician ' s orders on 6/25/19 included the psychotropic medications Geodon, Ativan, Buspar, and Trazodone. Resident #8 had no physician ' s orders for hypnotic medication. The active care plan for Resident #8 included the focus area of the potential for adverse side effects related to the use psychotropic medications/antianxiety medications/hypnotic medications/antidepressant medications. This focus area was initiated on 5/23/17 by MDS Nurse #1 and most recently revised on 4/16/19. Resident #8 ' s care plan had not addressed the use of antipsychotic medication. An interview was conducted with MDS Nurse #1 on 6/27/19 at 9:30 AM. The care plan for Resident #8 related to psychotropic medication that indicated the resident was on antianxiety medication, hypnotic medication, and antidepressant medication was reviewed with MDS Nurse #1. Resident #8 ' s physician ' s orders that indicated she was on antipsychotic medication, antianxiety medication, and antidepressant medication, but no hypnotic medication was reviewed with MDS Nurse #1. MDS Nurse #1 stated that she coded the 4/12/19 MDS assessment for 7 of 7 hypnotics based on Resident #8 ' s receipt of Buspar and Ativan. She revealed that she had been completing MDS assessments for over 2 decades and that she	F 656	Nurses. 3. Address what measures will be put into place of systemic changes made to ensure that the deficient practice will not occur: 3a. Regional Director of Clinical Services educated both Minimum Data Set Nurses on developing a comprehensive, person-centered, and individualized care plans in the aeas of psychotropic medications and diagnosis. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: 4a. Director of Nursing/Assistant Director of Nursing will follow the weekly care plan schedule and conduct an audit weekly x 12 weeks in the areas of individualized care plan, in the areas of psychotropic medications and individualized care plan in the area of diagnoses. Results of the audit will be reviewed monthly for 3 months by the Quality Assurance Process Improvement Committee. If any discrepancies are identified, further action will be implemented. 5. Date of Compliance: 07/23/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 15	F 656		

had always coded the antianxiety medications of Buspar and Ativan as both antianxiety medications and hypnotic medications on the MDS. She explained that because she coded the MDS assessment for hypnotic medication that she had also included this medication on Resident #8 ' s psychotropic care plan. MDS Nurse #1 was asked why Resident #8 ' s care plan had not included antipsychotic medication. MDS Nurse #1 was unable to explain why the use of antipsychotic medication was not incorporated into Resident #8 ' s care plan.

An interview was conducted with the Director of Nursing on 6/27/19 at 10:30 AM. She indicated that she expected care plans to be comprehensive, person-centered, individualized, and to reflect the current status of the resident.

2. Resident #12 was most recently readmitted to the facility on 10/24/18 with diagnoses that included anxiety disorder and depression.

A review of Resident #12 ' s April 2019 physician ' s order summary included the psychotropic medications Buspar (antianxiety medication) and Zoloft (antidepressant medication). Resident #12 had no physician ' s orders for hypnotic medication.

The quarterly Minimum Data Set (MDS) assessment dated 4/19/19 indicated Resident #12 ' s cognition was intact. He was coded by MDS Nurse #1 with 7 of 7 antianxiety medication, antidepressant medication, and hypnotic medication.

A review of Resident #12 ' s active physician ' s orders on 6/25/19 included the psychotropic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 16	F 656		

medications Buspar and Zoloft. Resident #12 had no physician ' s orders for hypnotic medication.

The active care plan for Resident #12 included the focus area of the potential for adverse side effects related to the use of antianxiety medication/hypnotic medication/antidepressant medication. This focus area was initiated on 8/27/18 by MDS Nurse #2 and most recently revised on 1/30/19.

An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 6/27/19 at 9:30 AM. MDS Nurse #1 and MDS Nurse #2 indicated they shared the responsibility of developing and revising care plans. The care plan for Resident #12 related to psychotropic medication that indicated the resident was on antianxiety medication, hypnotic medication, and antidepressant medication was reviewed with MDS Nurse #1 and MDS Nurse #2. Resident #12 ' s physician ' s orders that indicated he was on antianxiety medication and antidepressant medication, but not on hypnotic medication was reviewed with MDS Nurse #1 and MDS Nurse #2. MDS Nurse #1 stated that she coded the 4/19/19 MDS assessment for 7 of 7 hypnotics based on Resident #12 ' s receipt of Buspar. She revealed that she had been completing MDS assessments for over 2 decades and that she had always coded the antianxiety medications of Buspar and Ativan as both antianxiety medication and hypnotic medication on the MDS. She explained that because she coded the MDS assessment for hypnotic medication that she had also included this medication on Resident #12 ' s psychotropic care plan. MDS Nurse #2 also indicated she had been trained to code the antianxiety medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 17	F 656		

Buspar as both an antianxiety medication and hypnotic medication on the MDS which would have explained why the care plan included hypnotic medication.

An interview was conducted with the Director of Nursing on 6/27/19 at 10:30 AM. She indicated that she expected care plans to be comprehensive, person-centered, individualized, and to reflect the current status of the resident.

3. Resident #20 was most recently readmitted to the facility on 11/7/18 with diagnoses that included major depressive disorder.

The quarterly Minimum Data Set (MDS) assessment dated 6/13/19 indicated Resident #20 ' s cognition was intact. She received antidepressant medication on 7 of 7 days and no other psychotropic medication.

A review of Resident #20 ' s active physician ' s orders included the psychotropic medications Amitriptyline (antidepressant medication) and Duloxetine (antidepressant medication).

The active care plan for Resident #20 included the focus area of the potential for adverse side effects related to the use of antidepressant medication/antianxiety medication/hypnotic medication. This focus area was initiated by MDS Nurse #1 on 7/7/17 and most recently revised on 3/20/19.

An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 6/27/19 at 9:30 AM. MDS Nurse #1 and MDS Nurse #2 indicated they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 18	F 656		

shared the responsibility of developing and revising care plans. The care plan for Resident #20 related to psychotropic medication that indicated the resident was on antianxiety medication, hypnotic medication, and antidepressant medication was reviewed with MDS Nurse #1 and MDS Nurse #2. Resident #20 ' s physician ' s orders that indicated she was on antidepressant medication, but not on antianxiety medication or hypnotic medication was reviewed with MDS Nurse #1 and MDS Nurse #2. MDS Nurse #2 stated that Resident #20 had a PRN (as needed) order for Vistaril (antihistamine medication). She explained that she had been trained to code Vistaril as both an antianxiety medication and hypnotic medication on the MDS. She further explained that since she would ' ve coded Vistaril on the MDS assessment as an antianxiety medication and hypnotic medication that this was why it was included on Resident #20 ' s care plan as an antianxiety and hypnotic medication. MDS Nurse #1 also indicated she had been trained to code Vistaril as both an antianxiety medication and hypnotic medication on the MDS which would have explained why the care plan included antianxiety and hypnotic medication.

An interview was conducted with the Director of Nursing on 6/27/19 at 10:30 AM. She indicated that she expected care plans to be comprehensive, person-centered, individualized, and to reflect the current status of the resident.
4.
Resident #45 was admitted to the facility on 4/26/19 with diagnoses of chronic obstructive pulmonary disease (COPD) and dysphagia.

A review of Resident #45 ' s 5-day Minimum Data

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 19	F 656		

Set dated 6/5/19 for reentry from the hospital revealed a severely impaired cognition. The resident required extensive assistance of 1 staff for all activities of daily living. The active diagnoses were pneumonitis related to food and vomit inhalation and COPD.

A review of Resident #45 ' s comprehensive care plan did not reveal a focus, goals or interventions for respiratory diagnosis or dysphagia.

A review of Resident #45 ' s nursing note dated 5/22/2019 revealed she was called to the resident ' s room due to resident vomiting. The resident had decreased alertness and elevated heart rate of 134. The Nurse Practitioner was notified, and the resident was transferred to the hospital.

A review of Resident #45 ' s nursing readmission note from the hospital dated 5/29/2019 at 4:25 pm revealed the resident had pneumonia and acute hypoxemia and will continue on antibiotics. Summary: aspiration secondary to emesis.

A review of Resident #45's physician order dated 6/1/19 revealed a mechanically atered diet.

An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 6/27/19 at 9:30 AM. MDS Nurse #1 and MDS Nurse #2 indicated they shared the responsibility of developing and revising care plans. The care plan for Resident #45 related to the resident ' s recent pneumonia, hypoxemia and dysphagia was reviewed with MDS Nurse #1 and MDS Nurse #2. Both commented they did not know why there was no care plan for dysphagia.

An interview was conducted with the Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 20 Nursing on 6/27/19 at 10:30 AM. She indicated that she expected care plans to be comprehensive, person-centered, individualized, and to reflect the status of the resident.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to administer the prescribed oxygen rate for 2 (Resident #55 and Resident #207) of 4 residents reviewed the respiratory care. The findings included: 1. Resident #55 was admitted 6/6/19 with cumulative diagnoses of Congestive Heart Failure and Atrial Fibrillation. Review of Resident #55's admission orders dated 6/6/19 indicated he was prescribed oxygen at the rate of 2 liters per minute(L/Min) via nasal cannula. Resident #55's admission care plan dated 6/7/19 read was receiving oxygen therapy with the intervention of administering his oxygen as ordered.	F 695	F695 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1a. Resident #55 Oxygen delivery was adjusted to rate ordered by the physician by the nurse for assigned resident. Resident #207 - Oxygen delivery was adjusted to rate ordered by the physician by the nurse for assigned resident - resident discharged from facility. 2. Address how corrective action will be accomplished for those residents having the potential to be affected by the deficient practice: 2a. 100% of all residents receiving oxygen by tank and/or concentrator were visually	7/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 21 Review of Resident #55's admission Minimum Data Set (MDS) dated 6/13/19 indicated he was cognitively intact and exhibited no behaviors. He was coded as receiving oxygen. Review of Resident #55's Medication Administration Record (MAR) for June 2019 did not listed his ordered oxygen. In an observation and interview on 6/25/19 at 9:40 AM, Resident #55 was lying in bed wearing his oxygen at the incorrect rate of 3L/Min. His oxygen was being delivered using the electric oxygen concentrator. He voiced no shortness of breath. In an observation on 6/25/19 at 3:20 PM, Resident #55 was asleep in bed wearing his oxygen at the incorrect rate of 3L/Min. His oxygen was being delivered using the electric oxygen concentrator In an interview on 6/25/19 at 3:45 PM, the Director of Nursing (DON) stated the facility did not have a policy on oxygen therapy but rather followed the physician's orders. Review of a physician order dated 6/25/19 at 6:22 PM read Resident #55 was to receive oxygen at the rate of 2L/Min as needed to maintain an oxygen saturation level at or above 94%. This order was added to the MAR on 6/25/19. In an observation on 6/26/19 at 9:25 AM, Resident #55 was sitting in his wheelchair wearing portable oxygen running at the prescribed rate of 2L/Min. He stated he wanted to lie down in bed.	F 695	audited and validated, by Director of Nursing (DON) and Nurse in Charge on 06/27/2019 for receiving correct delivery rate ordered per physician without any noted issues. 2b. 100% of Licensed Nurses were re-educated by the DON on following physician orders regarding oxygen delivery to include view of settings at eye level to ensure resident(s) is receiving appropriate oxygen flow with concentrator and/or oxygen tank on 06/28/2019. 3. Address what measures will be put in place, or systemic changes made to ensure that the deficient practice will not occur: 3a. The facility DON to in-service all Licensed Nurses on ensuring if a resident has an order for oxygen, that the oxygen amount is checked at eye level, and that any portable oxygen tanks utilized by the resident is checked for correct level/amount as ordered per physician. 3b. All new Licensed Nurses hired will be educated on ensuring that residents on oxygen have an order for oxygen, that the oxygen amount is checked at eye level, and that any portable oxygen tanks utilized by the resident is checked for correct level/amount as ordered by physician. 4. Indicate how the facility plans to monitor it's performance to make sure the solutions are sustained: 4a. Facility DON and/or Nurse in Charge will review resident's medical record and maintain those resident's physician orders	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 22 In an observation on 6/26/19 at 9:35 AM, Resident #55 was lying in bed wearing his oxygen at the incorrect rate of 3L/Min. His oxygen was being delivered using the electric oxygen concentrator. In an observation on 6/26/19 at 3:10 PM, Resident #55 was lying in bed wearing his oxygen at the incorrect rate of 3L/Min. His oxygen was being delivered using the electric oxygen concentrator. In an interview on 6/26/19 at 3:12 PM, the Rehabilitation Manager stated Resident #55 was receiving Occupational, Physical and Speech Therapy. She stated therapy did not adjust Resident #55's ordered oxygen rate unless the physician indicated an oxygen administration range. She stated if Resident #55 appeared short of breath on his prescribed 2L/Min, the nurse would inform the physician for orders to increase his oxygen rate. In an interview on 6/26/19 at 3:20 PM, Nursing Assistant (NA) #1 stated at no time did the aides adjust Resident #55's oxygen rate. She stated the nurse was responsible for maintaining Resident #55's oxygen at the prescribed rate. NA #1 stated she had never observed Resident #55 adjusting his own oxygen rate. In an interview on 6/26/19 at 3:20 PM, NA #4 stated the aides do not adjust Resident #55's oxygen rate. She stated the nurse was responsible for maintaining Resident #55's oxygen at the prescribed rate. NA #4 stated she had never observed Resident #55 adjusting his own oxygen rate.	F 695	for oxygen 5x's/week x 2 weeks; then 3x's/week for 2 weeks then weekly for 8 weeks during morning rounds and the clinical morning meeting to ensure that the oxygen is begin administered per physician orders as warranted for 12 weeks beginning 06/28/2019. Results of the audit will be reviewed monthly for 3 months by the QAPI Committee. If discrepancies are noted, further action will be implemented. 5. Date of Compliance: 07/23/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 23	F 695		

In an interview on 6/26/19 at 3:25 PM, Nurse #1 stated Resident #55's ordered oxygen rate was 2L/Min. She stated she had never observed Resident #55's adjusting his oxygen rate and she had received no reports that he was adjusting his oxygen delivery rate.

In an interview on 6/26/19 at 4:10 PM, the DON stated it was her expectation that Resident #55 receive his oxygen at the prescribed rate of 2L/Min.

2. Resident #207 was admitted 6/19/19 with cumulative diagnoses of Chronic Obstructive Pulmonary Disease and Asthma.

Resident #207's admission Minimum Data Set was still in progress.

Resident #207's admission physician orders dated 6/19/19 read she was prescribed oxygen at 2 liters per minute (L/Min) via nasal cannula.

Review of Resident #207's baseline care plan dated 6/20/19 indicated she had a diagnosis of Asthma and receiving oxygen.

Review of Resident #207's Medication Administration Record (MAR) for June 2019 listed her ordered oxygen at 2L/Min as a notation but the nurse's were not initialing that it was being administered at the prescribed rate.

In an observation and interview on 6/25/19 at 9:55 AM, Resident #207 was lying in bed wearing her oxygen running at the incorrect rate of 1.5 L/Min. Her oxygen was being delivered using the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 24	F 695		

electric oxygen concentrator. She voiced no shortness of breath.

In an observation on 6/25/19 at 3:15 PM, Resident #207 was propelling her wheelchair in the hall wearing portable oxygen running at the prescribed rate of 2L/Min.

In an observation on 6/25/19 at 4:30 PM, Resident #207 was lying in bed. Her electric oxygen concentrator was running at the incorrect rate of 1.5 L/Min but her nasal cannula was lying across her nightstand out of her reach. Resident #207 motioned that she needed her oxygen. Nursing Assistant (NA) #2 was obtained and placed the oxygen on Resident #207 running at the incorrect rate of 1.5 L/Min. NA #2 stated when she put Resident #207 to bed, she forgot to apply her oxygen.

Review of a physician order dated 6/25/19 at 5:25 PM read Resident #207 was to receive oxygen at 2L/Min as needed for maintain an oxygen saturation level at or above 94%. This order was added to the MAR on 6/25/19.

In an observation on 6/26/19 at 3:15 PM, Resident #207 was sitting in the hall in her wheelchair. Her portable oxygen was running at the incorrect rate of 0.5L/Min. She did not appear in distress or short of breath. Nurse #2 was notified, and her rate was adjusted to the prescribed rate of 2L/Min.

In an interview on 6/26/19 at 3:16 PM, Nurse #2 stated she changed her portable oxygen tank approximately 10 minutes earlier and it was set for 2L/Min as ordered. She was unable to explain how her oxygen was running at 0.5L/Min.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 25 In an interview on 6/26/19 at 3:19 PM, NA #4 stated the aides were not allowed to turn on portable oxygen and not allowed to adjust oxygen rates of portable oxygen or electric oxygen concentrator. NA #4 stated it was the responsible of the nurse. She stated she had not witnessed Resident #207 adjusting her oxygen rate. In an interview on 6/26/19 at 3:30 PM, NA #3 stated the aides were not allowed to turn on portable oxygen and not allowed to adjust oxygen rates of portable oxygen or electric oxygen concentrator. NA #3 stated it was the responsible of the nurse. She stated she had not witnessed Resident #207 adjusting her oxygen rate. In an interview on 6/26/19 at 4:10 PM, the Director of Nursing (DON) stated she and Nurse #2 assessed Resident #207 after she was found wearing her portable oxygen at the rate of 0.5L/Min and believe that when Resident #207 propelled in her wheelchair, the back of her wheelchair hit the oxygen flow rate dial. She stated Resident #207's portable oxygen bag was adjusted so this would not occur again. The DON stated it was her expectation that Resident #207 receive her oxygen at the prescribed rate.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 700		7/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 26 §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to attempt interventions before side rail use and failed to reassess side rail use ongoing (Resident #8) for 1 of 1 reviewed for side rails. Findings included: Resident #8 was admitted to the facility on 5/23/17 with diagnoses of Schizo-effective disorder, epilepsy, and repeated falls. A review of Resident #8's Device Evaluation form dated 5/10/18 revealed reason for evaluation was quarterly. Interventions attempted were blank. A review of Resident #8's Device Evaluation form dated 8/2/18 revealed reason for evaluation was quarterly, the resident was alert with short and long term memory deficit, was cooperative, received antipsychotic medication, diuretic, and anti-hypertensive. The resident required assisted	F 700	F700 1. Address how corrective action will be accomplished for those residents found to have been affected by this deficient practice: 1a. Resident #8 - Bed rail audit completed on 6/26/2019 and bed frame was changed to fit scoop mattress at the direction of the Administrator to the Director of Nursing and Maintenance Director. 2. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: 2a. 100% audit was completed on all current residents in facility that have bed rails to ensure that the bed rail assessment was completed on 6/30/2019 and that bed rails are appropriate for each resident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 27 mobility in the bed and was assisted with transfer and wheelchair propel. The resident was visually impaired. Side rails were considered a positioning device. The form was signed by Nurse #3. Interventions attempted to date were none. Side rail usage determination was 1/2 right and left upper and that the device was necessary at this time. A review of Resident #8 ' s record revealed there were no further bed rail assessments from 8/2/18 to 6/25/19. A review of Resident #8 ' s quarterly Minimum Data Set dated 4/12/19 revealed the resident's vision was highly impaired. The resident had a severely impaired cognition. The resident required extensive assistance for activities of daily living. The active diagnoses were psychotic disorder and schizophrenia. A review of the nursing assistant's information sheet for care (undated) for Resident #8 revealed the resident had half side rails constantly. Resident #8 ' s care plan revealed it was updated 6/21/19 for 1/2 SRs for bed mobility and repositioning. The scoop mattress had been in place since 4/2018. On 6/26/19 at 11:35 am an observation was done of Resident #8 who received care by the Treatment Nurse (TN). The resident was able to move her upper body and hold on to the side rail at the head of her bed. The resident had a scoop mattress. On 6/26/19 at 11:35 am an interview was conducted with the TN who stated that the	F 700	2b. Current and newly admitted residents that require bed rails will have a quarterly assessment scheduled and reviewed for appropriateness of alternatives that will be placed on the care plan as to monitor effectiveness prior to applying bed rails. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: 3a. Administrator will educate the Maintenance Director and Director of Nursing (DON) regarding the FDA Guidelines and Manufactures' recommendations and specifications for installing and maintaining bed rails. 3b. 100% audit of bed rails completed by DON for appropriateness of intervention for resident(s) with bed rails with care plans updated appropriate for the resident. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: 4a. DON will audit bed rails weekly x 12 weeks per quarterly assessment schedule to ensure that bed rails continue to be appropriate and that appropriate alternatives are identified and care planned prior to placing a bed rail as intervention. Results of the audit will be reviewed monthly for 3 months by the QAPI Committee. If any discrepancies are noted, further action will be implemented. 5. Date of Compliance: 07/23/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 28 resident was able to use the bilateral head of the bed side rails to turn, hold during care, and reposition. The TN commented that the resident has had the side rails and uses them but could not recall how long. The TN indicated she was not familiar with a side rail assessment. On 6/26/19 at 12:15 pm an interview was attempted with Nurse #3 who was not available. On 6/26/19 at 1:25 pm an interview was conducted with the Director of Nursing (DON) who stated that interventions should be attempted before use of side rails, the side rail assessment should be done each quarter, and the form should be complete. The DON agreed that this had not been done for Resident #8. On 6/26/19 at 1:30 pm Resident #1's bed frame was changed to fit her scoop mattress by the Maintenance Supervisor and a completed side rail assessment was documented by the DON.	F 700		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		7/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 29	F 842		

must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 30 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to have accurate social service assessments related to psychiatric diagnoses and psychotropic medications for 5 of 5 residents reviewed for unnecessary medications (Residents #1, #8, #12, #20, and #55). The findings included: 1. Resident #20 was most recently readmitted to the facility on 11/7/18 with diagnoses that included major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated 6/13/19 indicated Resident #20 ' s cognition was intact. A social service assessment completed by the Social Worker (SW) dated 10/10/18 indicated Resident #20 had no current psychiatric-related diagnoses and was currently not taking psychoactive medication. A review of the physician ' s order summary dated 10/10/18 indicated Resident #20 was prescribed Amitriptyline (antidepressant medication) and	F 842	F842 1. Address how corrective action will be accomplished for those residents found to have been affected by this deficient practice: 1a. The Social Worker will correct resident #1, #8, #12, #20,and #55 annual Saber Social Service Evaluation. 2. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: 2a. When a resident is due for an annual Saber Social Services Evaluation by the Social Worker, the Social Worker is taking steps to assure they have the current psychiatric-related diagnoses and current psychoactive medications that the resident is receiving. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 31 Duloxetine (antidepressant medication). A social service assessment completed by the SW dated 11/16/18 indicated Resident #20 had no current psychiatric-related diagnoses and was currently not taking psychoactive medication. A review of the physician ' s order summary dated 11/16/18 indicated Resident #20 was prescribed Amitriptyline and Duloxetine. A social service assessment completed by the SW dated 2/5/19 indicated Resident #20 had no current psychiatric-related diagnoses and was currently not taking psychoactive medication. A review of the physician ' s order summary dated 2/5/19 indicated Resident #20 was prescribed Amitriptyline and Duloxetine. A social service assessment completed by the SW dated 5/3/19 indicated Resident #20 had no current psychiatric-related diagnoses and was currently not taking psychoactive medication. A review of the physician ' s order summary dated 5/3/19 indicated Resident #20 was prescribed Amitriptyline and Duloxetine. A social service assessment completed by the SW dated 6/11/19 indicated Resident #20 had no current psychiatric-related diagnoses and was currently not taking psychoactive medication. A review of the physician ' s order summary dated 6/11/19 indicated Resident #20 was prescribed Amitriptyline and Duloxetine. An interview was conducted with the SW on 6/26/19 at 11:15 AM. The SW stated that the purpose of the social service assessments was to be up to date on the current status of the resident and to identify if there were any needs or	F 842	occur: 3a. Administrator will educate the Social Worker regarding accuracy of the Saber Social Services Evaluation Annual in the areas of psychiatric diagnoses and psychotropic medications on the admission and annual assessments. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: 4a. Director of Nursing will audit all annual Saber Social Services Evaluation in section F weekly x 12 weeks per annual assessment schedule to ensure that assessment continues to have appropriate documentation. Results of the audit will be reviewed monthly for 3 months by the QAPI committee. If any discrepancies are noted, further action will be implemented. 5. Date of Compliance: 07/23/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 32	F 842		

concerns. The social service assessments dated 10/10/18, 11/16/18, 2/5/19, 5/3/19, and 6/11/19 for Resident #20 that indicated she had no psychiatric-related diagnoses and no current psychoactive medications were reviewed with the SW. A review of the physician ' s order summaries from 10/10/18, 11/16/18, 2/5/19, 5/3/19, and 6/11/19 that indicated Resident #20 had psychiatric-related diagnoses and psychoactive medications at the time of each social service assessment were reviewed with the SW. The SW stated that she reviewed the Medication Administration Records, the resident ' s diagnoses list, and talked with the MDS Nurses to complete her assessments. She was unable to explain why these 5 assessments were completed inaccurately for Resident #20.

An interview was conducted with the Director of Nursing on 6/27/19 at 10:30 AM. She indicated that she expected social service assessments to be completed accurately.

2. Resident #12 was most recently readmitted to the facility on 10/24/18 with diagnoses that included anxiety disorder and depression.

The quarterly Minimum Data Set (MDS) assessment dated 4/19/19 indicated Resident #12 ' s cognition was intact.

A social service assessment completed by the Social Worker (SW) dated 10/30/18 indicated Resident #12 had no current psychiatric-related diagnoses and was currently not taking psychoactive medication. A review of the physician ' s order summary dated 10/30/18 indicated Resident #12 was prescribed Buspar (antianxiety medication) and Zoloft

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 33	F 842		

(antidepressant medication).

A social service assessment completed by the SW dated 1/23/19 indicated Resident #12 had no current psychiatric-related diagnoses and was currently not taking psychoactive medication. A review of the physician ' s order summary dated 1/23/19 indicated Resident #12 was prescribed Buspar and Zoloft.

A social service assessment completed by the SW dated 4/18/19 indicated Resident #12 had no current psychiatric-related diagnoses and was currently not taking psychoactive medication. A review of the physician ' s order summary dated 4/18/19 indicated Resident #12 was prescribed Buspar and Zoloft.

A social service assessment completed by the SW dated 6/25/19 indicated Resident #12 had no current psychiatric-related diagnoses and was currently not taking psychoactive medication. A review of the physician ' s order summary dated 6/25/19 indicated Resident #12 was prescribed Buspar and Zoloft.

An interview was conducted with the SW on 6/26/19 at 11:15 AM. The SW stated that the purpose of the social service assessments was to be up to date on the current status of the resident and to identify if there were any needs or concerns. The social service assessments dated 10/30/18, 1/23/19, 4/18/19, and 6/25/19 for Resident #12 that indicated he had no psychiatric-related diagnoses and no current psychoactive medications were reviewed with the SW. A review of the physician ' s order summaries from 10/30/18, 1/23/19, 4/18/19, and 6/25/19 that indicated Resident #12 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 34	F 842		

psychiatric-related diagnoses and psychoactive medications at the time of each social service assessment were reviewed with the SW. The SW stated that she reviewed the Medication Administration Records, the resident ' s diagnoses list, and talked with the MDS Nurses to complete her assessment. She was unable to explain why these 4 assessments were completed inaccurately for Resident #12.

An interview was conducted with the Director of Nursing on 6/27/19 at 10:30 AM. She indicated that she expected social service assessments to be completed accurately.

3. Resident #8 was admitted to the facility on 5/23/17 with diagnoses that included anxiety disorder, schizophrenia, and psychosis.

The quarterly Minimum Data Set (MDS) assessment dated 4/12/19 indicated Resident #8 ' s cognition was severely impaired.

A social service assessment completed by the Social Worker (SW) dated 1/16/19 indicated Resident #8 had no current psychiatric-related diagnoses and was currently not taking psychoactive medication. A review of the physician ' s order summary dated 1/16/19 indicated Resident #8 was prescribed Ativan (antianxiety medication), Buspar (antianxiety medication) and Geodon (antipsychotic medication).

A social service assessment completed by the SW dated 4/10/19 indicated Resident #8 had no current psychiatric -related diagnoses and was currently not taking psychoactive medication. A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 35	F 842		

review of the physician ' s order summary dated 4/10/19 indicated Resident #8 was prescribed Ativan, Buspar, Geodon, and Trazodone.

A social service assessment completed by the SW dated 6/18/19 indicated Resident #8 had no current psychiatric-related diagnoses and was currently not taking psychoactive medication. A review of the physician ' s order summary dated 6/18/19 indicated Resident #8 was prescribed Ativan, Buspar, Geodon, and Trazodone.

An interview was conducted with the SW on 6/26/19 at 11:15 AM. The SW stated that the purpose of the social service assessments was to be up to date on the current status of the resident and to identify if there were any needs or concerns. The social service assessments dated 1/16/19, 4/10/19, and 6/18/19 for Resident #8 that indicated she had no psychiatric-related diagnoses and no current psychoactive medications were reviewed with the SW. A review of the physician ' s order summaries from 1/16/19, 4/10/19, and 6/18/19 that indicated Resident #8 had psychiatric-related diagnoses and psychoactive medications at the time of each social service assessment were reviewed with the SW. The SW stated that she reviewed the Medication Administration Records, the resident ' s diagnoses list, and talked with the MDS Nurses to complete her assessment. She was unable to explain why these 3 assessments were completed inaccurately for Resident #8.

An interview was conducted with the Director of Nursing on 6/27/19 at 10:30 AM. She indicated that she expected social service assessments to be completed accurately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 36	F 842		

4. Resident #55 was admitted 6/6/19 with a diagnosis of Depression.

Review of Resident #55's admission orders dated 6/6/19 indicated he was prescribed Paxil (antidepressant) daily for Depressive Disorder.

Resident #55's admission care plan dated 6/7/19 read he had a psychiatric disorder related to Depression and receiving antidepressant medication.

Review of Resident #55's admission Minimum Data Set (MDS) dated 6/13/19 indicated he was cognitively intact and exhibited no behaviors. He was coded for Depression and as taking an antidepressant. Resident #55's Care Area Assessment indicated he was prescribed Paxil and he would be care planned for the antidepressant.

Review of the admission Social Services Evaluation dated 6/7/19 under section F (Social Service Intervention Status) listed a question regarding Resident #55's current psychiatric diagnosis. Section F was coded as Resident #55 having no psychiatric diagnosis and as taking no psychoactive medications.

Review of Resident #55's June 2019 Medication Administration Record (MAR) from 6/6/19 through 6/26/19 indicated he received Paxil daily as ordered for Depression.

In an interview on 6/26/19 at 11:15 AM, the Social Worker confirmed she completed the Social Services Evaluation dated 6/7/19. She stated the purpose of the Social Service Evaluation was to determine the status of Resident #55 and to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 37	F 842		

assist with determining any needs or concerns. The Social Worker stated she received her information regarding psychiatric diagnoses and psychoactive medications from the MDS Nurses and the electronic medical record. The Social Worker stated she was not "clinical" therefore, the MDS Nurse assisted her. She stated the incorrect Social Service Evaluation for #55 dated 6/7/19 " must be an oversight" and was unable to explain why she didn't have it completed accurately.

In an interview on 6/27 at 10:30 AM, the Director of Nursing stated it was her expectation that the Social Services Evaluation be accurate in Section F for Diagnosis and psychoactive medications.

5. Resident #1 was admitted to the facility on 2/9/18 with diagnosis of Alzheimer ' s Dementia.

A review of Resident #1 ' s care plan dated 3/22/19 and updated 4/11/19 revealed goals and interventions for confusion and has memory deficit.

A review of Resident #1 ' s quarterly Minimum Data Set dated 6/14/19 revealed the resident had highly impaired vision and hearing and a severely impaired cognition. The resident had psychosis and no behaviors. The resident required extensive assistance of 1 for transfer and locomotion, was totally dependent for toileting and personal care, and set up for meals. The active diagnoses were psychotic disorder and dementia. The resident received for 7 days an anti-psychotic, anti-anxiety, and hypnotic.

A social service assessment completed by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 38 Social Worker (SW) dated 6/12/19 indicated Resident #1 had no current psychiatric-related diagnoses and was currently not taking psychoactive medication. A review of the physician ' s order summary dated 6/1/19 indicated Resident #1 was prescribed Ativan (antianxiety medication) and Seroquel (antipsychotic medication). An interview was conducted with the SW on 6/26/19 at 11:15 AM. The SW stated that the purpose of the social service assessments was to be up to date on the current status of the resident and to identify if there were any needs or concerns. The social service assessment dated 6/12/19 for Resident #1 that indicated she had no psychiatric-related diagnoses and no current psychoactive medications were reviewed with the SW. A review of the physician ' s order dated 6/1/19 indicated Resident #12 had psychiatric-related diagnoses and psychoactive medications at the time of the social service assessment was reviewed with the SW. The SW stated that she reviewed the Medication Administration Records, the resident ' s diagnoses list, and talked with the MDS Nurses to complete her assessment. She was unable to explain why this assessment was completed inaccurately for Resident #1. An interview was conducted with the Director of Nursing on 6/27/19 at 10:30 AM. She indicated that she expected social service assessments to be completed accurately.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		7/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 39 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and resident, and staff interviews the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put in place following the recertification/complaint survey of 4/5/18. This was for 1 deficiency originally cited 4/5/18 and was subsequently recited on the current recertification survey of 6/27/19. The recited deficiency was in the area of Minimum Data Set accuracy. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: The tag is cross referenced to: F-641 Accuracy of Assessments: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of medications (Residents #1, #8, #12, and #57) for 4 of 6 residents whose medications were reviewed. During the prior survey of 4/5/18 the facility failed to have accurately coded the Minimum Data Set assessment in the area of psychotropic medication (Resident #42) for 1 of 5 sampled residents.	F 867	F867 1. The QAPI Process was re-evaluated by the Administrator and Director of Nursing on 7/9/19 including the monitoring of F-641. The Administrator and the Director of Nursing reviewed the Federal Regulation for F-641. 2. The Administrator and Director of Nursing will review the prior QAPI minutes and QAPI Audits by 7/23/2019 to identify any need for additional monitoring. 3. On 7/18/2019 the Administrator and the QA Committee received education by the Regional Director of Clinical Services related to maintaining implemented procedures and follow up monitoring of the interventions or procedures that are implemented in order to sustain compliance as required. 4. The Administrator and/or Director of Nursing will complete audits monthly for 1 year to ensure systems and process continue to be monitored and follow up completed as required. The Administrator will be responsible for monitoring and follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 40 On 6/27/19 at 11:00 am an interview was conducted with the Administrator who stated the root cause for the repeat tag was human error.	F 867	Date of Compliance: 7/23/2019	
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to evaluate the bed frame to mattress size for compatibility and to regularly inspect bedrails, mattresses and bedframes (Resident #8) for 1 of 1 reviewed for physical environment. Findings included: Resident #8 was admitted on to the facility on 5/23/17 with diagnoses of Schizo-effective disorder, epilepsy, bipolar disorder, and repeated falls. A review of Resident #8's Device Evaluation form (side rails) dated 5/10/18 revealed reason for evaluation was quarterly. Interventions attempted were blank. A review of Resident #8's Device Evaluation form (side rails) dated 8/2/18 revealed reason for evaluation was quarterly, the resident was alert	F 909	F909 1. Address how corrective action will be accomplished for those residents found to be affected by this deficient practice: 1a. Resident #8 bed rail assessment completed on 6/26/2019 and bed frame was changed to fit scoop mattress by direction of the Administrator to the Director of Nursing and Maintenance Director. 2. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: 2a. 100% Audit was completed on all current residents in the facility that has bed rails to ensure that bed rail assessment was completed on 6/30/2019 and the bed rails are appropriate for each resident. 100% bed rail equipment audit	7/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909	Continued From page 41 with short and long term memory deficit, was cooperative, received antipsychotic, anti-anxiety, diuretic, and anti-hypertensive. The resident required assisted mobility in the bed and was assisted with transfer and wheelchair propel. The resident was visually impaired. Side rails were considered a positioning device. Interventions attempted to dated were none. Side rail usage determination was 1/2 right and left upper and that the device was necessary at this time. The form was signed by Nurse #3. A review of the record revealed there were no further bed rail assessments from 8/2/18 to 6/25/19. A review of Resident #8 ' s quarterly Minimum Data Set dated 4/12/19 revealed the resident's vision was highly impaired. The resident had a severely impaired cognition. The resident required extensive assistance of 1 staff activities of daily living. The active diagnoses were psychotic disorder and schizophrenia, Resident #8 ' s care plan revealed it was updated 6/21/19 for 1/2 side rails for bed mobility and repositioning. The scoop mattress had been in place since 4/2018. On 6/26/19 at 11:35 am an observation was done of Resident #8 who had a scoop mattress and ½ bilateral side rails at the head of the bed. The Maintenance Supervisor (MS) also observed the side rail attachment space and agreed that the space could potentially cause a problem. The MS indicated the rail attachment could be removed easily and observed the roommate's bed where the rail attachment had already been	F 909	tool was performed by the Maintenance Director on 7/12/2019 to ensure bed dimensions, bed rails and mattress were appropriate for the bed frame. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: 3a. Administrator will educate the Maintenance Director and Director of Nursing regarding the FDA Guidelines and Manufactures' recommendations and specifications for installing and maintaining bed rails. 3b. 100% audit of bed rails was completed by DON for appropriateness of intervention for resident(s) with bed rails with care plans updated appropriately for the resident. 4. Indicate how the facility plans to monitor it performance to make sure that solution are sustained: 4a. Director of Nursing will audit bed rails weekly x 12 weeks per quarterly assessment schedule to ensure that continues to be appropriate and that appropriate alternatives are identified and care planned prior to placing a bed rail as intervention. Results of the audit will be reviewed monthly for 3 months by the QAPI Committee. If any discrepancies are noted, further action will be implemented. Maintenance Director will perform a bi-annual audit of all bed frames, bed rails and mattresses to insure appropriateness for bed frame. Results will be reviewed by the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909	Continued From page 42 removed because side rails were not being used. The MS stated he had never noticed the space on Resident #89's bed frame and rail attachment and that the resident's mattress did not cover this area. MS did not comment at this time regarding the size of the mattress compared to the size of the bed frame. At 12:00 pm a measurement was made of the rail attachment that had a side rail in place on the head of the bed and a space of 2.25 inches was noted between the rail attachment with a side rail in place and the bed frame. Measurement of the space between the mattress and side rail was observed to be 4.25 inches. On 6/26/19 at 1:25 pm an interview was conducted with the Director of Nursing (DON) who stated that there were no other bed frames in the facility with rail attachments like Resident #8. The DON agreed that the scoop mattress does not properly fit in Resident #8's bed frame resulting in the space between the mattress and frame and was currently in the process of changing Resident #8's bed frame. The DON expected the resident ' s mattress to properly fit the bed frame. On 6/26/19 at 1:30 pm Resident #1's bed frame was observed to be changed to fit her scoop mattress by MS and there was no longer a 4.25-inch space between the mattress and bed rail. On 6/26/19 at 2:48 pm an interview was conducted with MS who stated he conducted a yearly bedrail and frame assessment to check for loose bolts, side rails, and bed mechanics. MS	F 909	5. Date of Compliance: 7/23/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909	Continued From page 43	F 909		

stated that nursing informed him about side rail issues and he addressed them. MS was not informed that there was an issue with Resident #8 ' s mattress fit with a space between the side rails. MS was responsible to make repairs of the bed. MS commented that the physician ordered the resident ' s mattress type and MS was responsible to make sure it fit the bed frame when changed. All mattresses were the same length with varying widths. MS stated he was responsible to evaluate the mattress width to the size of the bed frame. MS commented that if a mattress was too small for the bed frame the resident could get trapped. MS stated the wire curve at end and head of the bed held the mattress in place. Resident #8's bed frame did not have the wire curve that guided the size of the mattress. Resident #8's bed was an older bed. Older beds have standard frames 35 inches wide. Resident #9 ' s bed frame had a bariatric mattress for a prior resident that was no longer used. MS stated that he was not sure how long Resident #8 had been in the bed frame that does not match her mattress size. MS stated that there was not an acceptable space between Resident #8 ' s mattress and side rail. The space was too large. MS stated that he completed a bed rail safety inspection annually and the last inspection was dated 4/2/19. MS documented that he completed Resident #8's bed/rail/frame inspection and documented that they were compatible with each other. MS commented that he must had missed the space.