PRINTED: 07/29/2019 FORM APPROVED OMB NO. 0938-0391

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345392	B. WING		C 06/27/2019
	ROVIDER OR SUPPLIER DRO HEALTH & REHAE	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170	, 00.2.7.2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 000	INITIAL COMMENT	S	F 00	00	
F 565 SS=D	conducted from 6/24 allegations was substanced from 6/24 allegations was substanced from 6/85. The compliance with CFI Preparedness. Everometer Resident/Family Groups (September 1975) The resident/Family Groups (September 1975) The resident group, if one exists, reasonable steps, who make residents and upcoming meetings (ii) Staff, visitors, or resident group or farthe respective group (September 1975) The facility must person who is approgroup and the facility providing assistance requests that result (IV) The facility must resident or family groups concerning is in the facility. (A) The facility must response and ration (B) This should not be supposed from the facility must response and ration (B) This should not be supposed from the facility must response and ration (B) This should not be supposed from the facility must response and ration (B) This should not be supposed from the facility must response and ration (B) This should not be supposed from the facility must response and ration (B) This should not be supposed from the facility must response from the facility must response and ration (B) This should not be supposed from the facility must response from the facility must response and ration (B) This should not be supposed from the facility must response from the facility must res	pup and Response pup and Response pui)-(iv)(6)(7) resident has a right to organize sident groups in the facility. Provide a resident or family with private space; and take ith the approval of the group, and family members aware of in a timely manner. Pother guests may attend mily group meetings only at bis invitation. Provide a designated staff proved by the resident or family y and who is responsible for a and responding to written from group meetings. Consider the views of a poup and act promptly upon recommendations of such sesues of resident care and life to be able to demonstrate their ale for such response. Provide a designated staff provides and responding to written from group meetings. Consider the views of a poup and act promptly upon recommendations of such group and act prom	F 50	65	7/23/19
	§483.10(f)(6) The re participate in family	sident has a right to			
I ABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE	(X6) DATE

Electronically Signed 07/19/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345392	B. WING _			C 06/27/2019
	ROVIDER OR SUPPLIER DRO HEALTH & REHAB	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 565	family member(s) or representative(s) me families or resident residents in the facil This REQUIREMEN by: Based on record reresidents and staff, repeat concerns with during Resident Conconsecutive months. The findings include Review of the month minutes dated 4/3/1 related to bread being indicated, "the coverplates were causing due to steam being Dietary Manager (Dietary Manager	esident has a right to have other resident eet in the facility with the representative(s) of other ity. IT is not met as evidenced view, and interviews with the facility failed to resolve in food palatability reported uncil meetings for 2	F 5		ion of this plan ro Health and onstitute an by the provider of ed or the sions set forth encies. The and federal e action will be sidents found to deficient participate in otified of the read from	
	The meetings indica assured the DM was bags. These minute Activities Director. A Resident Council 6/25/19 at 3:00 PM	at tolls still being soggy. Ited that the residents were so working on getting bread es were recorded by the meeting was conducted on with 10 alert and oriented active participants in the		accomplished for those re potential to be affected by deficient practice: 2a. Current residents that will be served in a clear pl each meal to prevent dam when placed on tray.	sident's having the same receive bread astic flip bag at	

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		345392	B. WING			C	
NAME OF D		343332	D. WING_	OTDEET ADDRESS SITV OF	<u> </u>	06/27/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST			
WADESBO	ORO HEALTH & REHAB	CENTER		2051 COUNTRY CLUB ROA	AD		
**********	,			WADESBORO, NC 2817	70		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 565	Continued From page	e 2	F 5	65			
	facility's Resident Co				neasures will be put int	to I	
	-	d a repeat concern related to			changes to ensure that		
		soggy when served at lunch		the deficient practic	_	Δt	
		eting attendees all stated that			will educate the Dietary	,	
		nis issue with the DM during			Director and Social	y	
	-	neeting a couple of months			ince of how to complet	to I	
		ed she would get bags for		· ·	rievances/concerns		
	_	e the issue of the bread		discussed in Resid			
becoming soggy. The residents reported that this				ncil meeting minutes			
	concern had not yet been resolved and that their				ed for last 3 months by	,	
	•	nued to be soggy when			o ensure all grievance		
	served to them.			I	ave been addressed		
				from Resident Cou			
	An interview was con	ducted with the DM on		3c. Activities Direct	_		
	6/26/19 at 8:45 AM.	She confirmed she had		Worker will ask dur	ring Resident Council		
	attended a few of the	Resident Council meetings		meeting for the nex	xt 3 months about the		
	and that she was awa	are of the repeat concern		bread being served	d and is it without		
	voiced by the residen	its related to bread and rolls		dampness. Any gr	rievances/concerns wi	II	
	being soggy when se	rved. She stated that she		be reported to the	Administrator.		
	had informed the resi	dents she would obtain		3d. Administrator v	will review the Residen	nt	
	bread bags to elimina	ate the issue of soggy bread.		Council Meeting m	ninutes and the concer	n	
	The DM explained the	at if the bread and/or rolls		forms generated from	om them with the		
	were placed in a bag	that it would prevent steam		Activities Director a	and Social Worker afte	er	
		oread product causing it to		each meeting.			
	• • • • • • • • • • • • • • • • • • • •	eported that after she was		3e. Concerns will b			
		ne concern a couple of		grievance/concern	log for noting in		
		contacted her representative		trending.			
		ny to see if she could order					
	_	stated that she had not		4. Indicate how the	• •		
		that time and she had		1	nance to make sure the	е	
	forgotten to follow up	on this issue.		solutions(s) are su			
					and/or designee(s) will		
		ducted with the Activities			ces/concerns 5x/week	x	
		t 9:00 AM. She confirmed			week x 4 weeks and		
		he Resident Council had a		weekly x 4 weeks t			
	T	ed to bread and rolls being		grievances/concer		_	
		She stated that the DM was		I	mpleted timely. Resul		
		she was in attendance at			reviewed monthly x 3		
	the meeting when this	s was first discussed		months by the QAF	PI Committee. If any		

Facility ID: 923526

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345392	B. WING _				27/2019
	ROVIDER OR SUPPLIER DRO HEALTH & REHAB	CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170		951 COUNTRY CLUB ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 565	responsibility was to cheads were aware of the meetings for their was out of her hands An interview was con Nursing on 6/27/19 at	es Director reported that her ensure the department any concerns reported at departments, and that it from there. ducted with the Director of t 10:40 AM. She indicated nt Council repeat concerns		565	discrepancies are noted, further action be implemented. 5. Completion Date 7/23/2019	will	7/23/19
SS=E	§483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on record reversed facility failed to code of (MDS) assessment at medications (Resider active diagnosis (Resident #57) for 4 comedications were reversed for the findings included to the	is not met as evidenced iew and staff interview, the the Minimum Data Set ccurately in the areas of its #1, #8, #12, and #57), ident #8), and alarms of 6 residents whose iewed. : dmitted to the facility on es that included anxiety iia, psychosis, and epilepsy. ent #8's physician's order			1. Address how corrective action will be accomplished for those residents' found 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 Dos 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 a wander guard was corrected and resubmitted and care plan updated.	d to nd see s vas d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345392	B. WING_			C 06/27 /	2010
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP	CODE	00/2//	2013
				2051 COUNTRY CLUB ROAD			
WADESB	ORO HEALTH & REH	AB CENTER		WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(=:::::::::::::::::::::::::::::::::::::			(X5) COMPLETION DATE
F 641	Continued From poincluded no hypnood A review of the Met (MAR) for Resider 4/12/19 indicated Buspar and Ativan medications. The quarterly Minit assessment dated 's cognition was sooded with antiany medication on 7 of section of Resider coded by MDS Nuture An interview was con 6/27/19 at 9:30 of Resident #8 's a received hypnotic reviewed with MDS 's order summary Resident #8 had rewas reviewed with #1 stated that she for 7 of 7 hypnotic receipt of Buspar as he had been comover 2 decades and the antianxiety means both antianxiety means both antianxiety means on the An interview was considered.	age 4 tic medications for Resident #8. edication Administration Record at #8 from 4/6/19 through Resident #8 was administered on 7 of 7 days and no hypnotic mum Data Set (MDS) 4/12/19 indicated Resident #8 everely impaired. She was dety medication and hypnotic for 7 days. The medications at #8 's 4/12/19 MDS was rise #1. conducted with MDS Nurse #1 AM. The medications section 4/12/19 MDS that indicated she medication on 7 of 7 days was Son Nurse #1. The April physician and MAR that indicated eccived no hypnotic medication MDS Nurse #1. MDS Nurse coded this MDS assessment is based on Resident #8 's and Ativan. She revealed that apleting MDS assessments for a dications of Buspar and Ativan is medications of Buspar and Ativan is medications and hypnotic	F	DEFICIEN	e action will be esidents havind by the deficion of the last 30 for accuracy of coding for ediagnosis, ander guards if the last 30 for accuracy of coding for ediagnosis, ander guards if the last 30 for accuracy of coding the last 30 for accuracy of contactice will not be sometiment of the last 30 for accuracy of accuracy of accuracy of accuracy of accuracy of and/or last 30 for and have effect the last 30 for accuracy of and and have effect the last 30 for accuracy of and and have effect the last 30 for accuracy of and and have effect the last 30 for accuracy of and and have effect the last 30 for accuracy of and by a last 30 for accuracy of and and have effect the last 30 for accuracy of accuracy of and accuracy of	e g g ient into ot f t e e hat ar	
	_	the MDS to be coded		audit will be reviewed mo months by the QAPI Com discrepancies are noted, be implemented.	nthly for 3 nmittee. If any	,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345392	B. WING _			C 06/27/2019	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2172010
				20	051 COUNTRY CLUB ROAD		
WADESBO	ORO HEALTH & REHAB	CENTER		WADESBORO, NC 28170			
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F 641	F 641 Continued From page 5		F 6	641			
	5/16/18 indicated Geo	der for Resident #8 dated odon (antipsychotic rams (mg) in the morning.			5. Date of Compliance: 07/23/2019		
	1	for Resident #8 dated odon 40 mg at bedtime.					
	3/27/19 indicated that Geodon 60 mg in the This note indicated th	Practitioner (PNP) note dated t Resident #8 continued on morning and 40 mg at bed. at a dose reduction attempt adicated for Resident #8.					
	's cognition was seve coded with antipsych- days, routine usage of the last attempted Gr (GDR) date was 4/10 indicated that there was documentation that a contraindicated for Re	12/19 indicated Resident #8 erely impaired. She was otic medication on 7 of 7 of antipsychotics only, and adual Dose Reduction /18. This assessment also was no physician GDR was clinically esident #8. The medications 8 ' s 4/12/19 MDS was					
	on 6/27/19 at 9:30 AM of Resident #8 ' s 4/1 there was no physicia GDR was clinically co #8 was reviewed with 3/27/19 PNP note that clinically contraindica Nurse #1. MDS Nurse reviewed physician 's notes, and PNP notes MDS related to antips	ducted with MDS Nurse #1 M. The medications section 2/19 MDS that indicated an documentation that a contraindicated for Resident in MDS Nurse #1. The at indicated a GDR was ted was reviewed with MDS are #1 stated that she as note, Nurse Practitioner as to code this section of the sychotic medication GDRs. Applain why this MDS was					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345392	B. WING		C 06/27/2019		
	ROVIDER OR SUPPLIER DRO HEALTH & REHAE	3 CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 051 COUNTRY CLUB ROAD VADESBORO, NC 28170	1 33/21/2313		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE COMPLETION			
F 641	Continued From pag	ge 6	F 641				
		at there was no physician a GDR was clinically					
		nducted with the Director of at 10:30 AM. She indicated at MDS to be coded					
	focus area of the po a diagnosis of epiler initiated on 8/29/17. Resident #8 would be the next 90 day revie for this focus area in medications as orde effectiveness, possil notify physician/Nursindicated; observe for and report to physic	tare plan included, in part, the tential for seizures related to pay. This focus area was The goal indicated that per free from seizure activity in the period. The interventions actuded, in part, administer pered, observe for tolerance, tole adverse side effects, and the period of					
		/20/19 indicated that Resident assessment included, in part, ent seizures.					
	's cognition was sev was not coded with epilepsy/seizure disc section of Resident coded by MDS Nurs	7/12/19 indicated Resident #8 Freely impaired.					
	on 6/27/19 at 9:30 A	M. The active diagnoses #8 ' s 4/12/19 MDS that					

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	ROVIDER OR SUPPLIER ORO HEALTH & REHA			2051	ET ADDRESS, CITY, STATE, ZIP CODE COUNTRY CLUB ROAD DESBORO, NC 28170	1 00	12772019	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 641	disorder was review care plan that indice potential for seizure epilepsy that was a review period of the with MDS Nurse # that indicated epile was an active diagonal reviewed with MDS stated that she had an active diagnosis MDS as the reside seizure medication review period of the she had not viewed potential for seizure relationship to Ressof the 4/12/19 MDS An interview was conversing on 6/27/19	diagnosis of epilepsy/seizure wed with MDS Nurse #1. The sated the focus area of the es related to a diagnosis of an active care plan during the e 4/12/19 MDS was reviewed 1. The NP note dated 2/20/19 apsy and recurrent seizures nosis for Resident #8 was 8 Nurse #1. MDS Nurse #1 d not coded Resident #8 with a of epilepsy on the 4/12/19 and not seizures and no administered during the 7-day e 4/12/19 MDS. She indicated d the care plan related to the es as having a direct ident #8 's status at the time	F	641				
	the facility on 5/14/	as most recently admitted to 18 with diagnoses that 's disease, dementia, and						
		order for Resident #57 dated Buspar (antianxiety medication) hree times daily.						
	summary for Septe	nt #57 's physician 's order ember 2018 included Buspar 5						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	DATE	
F 641	medications for Resident A review of the Medic (MAR) for Resident 5/28/19 indicated she on 7 of 7 days and not assessment dated 9/1 s cognition was severed with antianxied medication on 7 of 7	cation Administration Record #57 from 9/22/18 through was administered Buspar o hypnotic medications. Im Data Set (MDS) 28/18 indicated Resident 57 erely impaired. She was ty medication and hypnotic days. The medications	Fé	541			
	on 6/27/19 at 9:30 Al of Resident #57 's 9/she received hypnoti was reviewed with M September 2018 phy MAR that indicated F hypnotic medication Nurse #2. MDS Nurse this MDS assessment on Resident #8 's re revealed that she had antianxiety medication on the MDS. An interview was con Nursing on 6/27/19 at that she expected the accurately.	rsician 's order summary and Resident #57 had received no was reviewed with MDS se #2 stated that she coded at for 7 of 7 hypnotics based ceipt of Buspar. She dibeen trained to code the on Buspar as both an on and hypnotic medication and ducted with the Director of the 10:30 AM. She indicated					

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	ROVIDER OR SUPPLIER ORO HEALTH & REHAB	1 111		STREET ADDRESS, CITY, STATE, ZIP COL 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170	•	10/2//2019		
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F 641	Continued From pag		F 6	41				
	a wander/elopement Resident #57.	alarm was in place for						
	(MAR) for Resident #	cation Administration Record \$57 from 9/22/18 through vander/elopement alarm was						
	's cognition was sev	28/18 indicated Resident 57 erely impaired. Resident DS Nurse #2 with no						
	on 6/25/19 at 4:25 Pl Resident #57 that ind wander/elopement al Nurse #2. The Septe indicated a wander/ed daily for Resident #5	larm was reviewed with MDS ember 2018 MAR that elopement alarm was in place 7 was reviewed with MDS aled this was an oversight						
		nducted with the Director of at 10:30 AM. She indicated a MDS to be coded						
		most recently readmitted to 18 with diagnoses that order.						
	11/12/18 indicated B	for Resident #12 dated uspar (antianxiety rams (mg) three times daily.						
	A review of Resident	#12 's physician 's order						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER DRO HEALTH & REHAB	CENTER	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD NADESBORO, NC 28170		
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F 641	three times daily. The order summary include for Resident #12.	e 10 19 included Buspar 10 mg e April 2019 physician 's ded no hypnotic medications eation Administration Record	F	641			
	(MAR) for Resident #	12 from 4/13/19 through was administered Buspar on					
	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.						
	on 6/27/19 at 9:30 AM of Resident #12 's 4/ received hypnotic me reviewed with MDS M 's order summary an Resident #12 had received medication was reviem MDS Nurse #1 stated assessment for 7 of 7 Resident #12 's receithat she had been cofor over 2 decades are coded the antianxiety an antianxiety medication on the ME An interview was considered.	wed with MDS Nurse #1. I that she coded this MDS I hypnotics based on ipt of Buspar. She revealed impleting MDS assessments and that she had always i medication Buspar as both ation and hypnotic DS. iducted with the Director of					
		t 10:30 AM. She indicated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG			SHOULD BE	(X5) COMPLETION DATE		
F 641	Continued From page that she expected the accurately. 4. Resident #1 was adn with the diagnosis of A review of Resident 3/22/19 and updated interventions for conf psychotropic medical A review of the Medic (MAR) for Resident #6/14/19 indicated Re Ativan on 7 of 7 days medications. A review of Resident Data Set (MDS) date resident had highly in and a severely impainad psychosis and no required extensive as daily living. The actividisorder and dement	e 11 e MDS to be coded nitted to the facility on 2/9/18 Alzheimer 's Dementia. #1 's care plan dated 4/11/19 revealed goals and fusion, memory deficit, and ficion. cation Administration Record from 6/7/19 through sident #1 was administered	F 6	DEFICIENCY)		
	on 6/27/19 at 9:30 Al of Resident #1 ' s 6/1 received hypnotic me reviewed with MDS N physician ' s order su indicated Resident #8 medication was revie MDS Nurse #1 stated assessment for 7 of 7	ducted with MDS Nurse #1 M. The medications section 4/19 MDS that indicated she edication on 7 of 7 days was Jurse #1. The June 2019 Immary and MAR that B had received no hypnotic wed with MDS Nurse #1. If that she coded this MDS T hypnotics based on of of Ativan. MDS Nurse #1				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER DRO HEALTH & REHAB	S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170	1 00/21/2013
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F 641	assessments for over had always coded Ar as both antianxiety medication on the M An interview was con Nursing on 6/27/19 at that she expected the	and been completing MDS or 2 decades and that she tivan, antianxiety medication medication and hypnotic DS. Inducted with the Director of at 10:30 AM. She indicated e MDS to be coded	F 64	41	
F 656 SS=D	CFR(s): 483.21(b)(1 §483.21(b)(1) The faimplement a compression resident rights set for §483.10(c)(3), that in objectives and timefined that are identificated t	Comprehensive Care Plan) nensive Care Plans acility must develop and shensive person-centered esident, consistent with the arth at §483.10(c)(2) and neludes measurable rames to meet a resident's d mental and psychosocial ified in the comprehensive mprehensive care plan must ag - are to be furnished to attain lent's highest practicable d psychosocial well-being as actually \$483.25 or \$483.40; and a would otherwise be required actually \$483.40 but are not resident's exercise of rights ding the right to refuse 3.10(c)(6). services or specialized es the nursing facility will	F 65	56	7/23/19

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F 656	resident's representa (A) The resident's go desired outcomes. (B) The resident's pr future discharge. Far whether the resident community was asse local contact agencie entities, for this purp (C) Discharge plans plan, as appropriate, requirements set fort section. This REQUIREMEN' by: Based on record rev facility failed to deve person-centered, and the areas of psychot #8, #12, and #20), a for 4 of 15 residents The findings included 1. Resident #8 was a 5/23/17 with diagnos disorder, schizophre A review of Resident s order summary inc medications Geodon Ativan (antianxiety medicati (antidepressant medications)	ent's medical record. th the resident and the ative(s)- pals for admission and eference and potential for cilities must document 's desire to return to the essed and any referrals to es and/or other appropriate ose. in the comprehensive care in accordance with the th in paragraph (c) of this T is not met as evidenced view and staff interview, the lop comprehensive, d individualized care plans in ropic medications (Residents and diagnoses (Resident #45) reviewed. d: admitted to the facility on ses that included anxiety nia, and psychosis. t #8 's April 2019 physician 's luded the psychotropic in (antipsychotic medication), medication), Buspar	F	656	F656 1. Address how corrective action will be accomplished for those residents' found have been affected by the deficient practice: 1a. Care plans have been corrected in 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 Region Reimbursement Specialist and the Director of Nursing. All deficient areas	the f e ig ient	
	The quarterly Minimu	um Data Set (MDS)			identified were corrected by the MDS		

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Continued From page	e 14	F 650	6	
assessment dated 4/ 's cognition was seve coded by MDS Nurse medication, antidepres antipsychotic medical medication. A review of Resident orders on 6/25/19 incomedications Geodon, Trazodone. Resident orders for hypnotic moders for hypnotic moders for hypnotic moders area of the potential of t	12/19 indicated Resident #8 erely impaired. She was e #1 with 7 of 7 antianxiety essant medication, tion, and hypnotic #8's active physician's eluded the psychotropic Ativan, Buspar, and t #8 had no physician's redication. for Resident #8 included the ential for adverse side use psychotropic ety medications/hypnotic ressant medications. This red on 5/23/17 by MDS recently revised on 4/16/19. The care plan for repsychotropic medication ident was on antianxiety medication, and reation was reviewed with dent #8's physician's she was on antipsychotic rety medication, and reation, but no hypnotic wed with MDS Nurse #1. If that she coded the 4/12/19	F 65	Nurses. 3. Address what measures will be pplace of systemic changes made to ensure that the deficient practice win occur: 3a. Regional Director of Clinical Set educated both Minimum Data Set Non developing a comprehensive, person-centered, and individualized plans in the aeas of psychotropic medications and diagnosis. 4. Indicate how the facility plans to monitor its performance to make su solutions are sustained: 4a. Director of Nursing/Assistant Director of Nursing will follow the weekly car schedule and conduct an audit weekly weeks in the areas of individuality care plan, in the areas of psychotro medications and individualized care in the area of diagnoses. Results of audit will be reviewed monthly for 3 months by the Quality Assurance Planprovement Committee. If any discrepancies are identified, further will be implemented. 5. Date of Compliance: 07/23/2019	rvices durses dicare rethat rector re plan kly x zed pic e plan of the rocess action
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR I Continued From page assessment dated 4/ 's cognition was seve coded by MDS Nurse medication, antidepre antipsychotic medica medication. A review of Resident orders on 6/25/19 inc medications Geodon, Trazodone. Resident orders for hypnotic m The active care plant focus area of the pote effects related to the medications/antidepre focus area was initiat Nurse #1 and most re Resident #8 's care puse of antipsychotic re An interview was con on 6/27/19 at 9:30 AN Resident #8 related to that indicated the res medication, hypnotic antidepressant medic MDS Nurse #1. Resi orders that indicated medication, antianxie antidepressant medic medication was review MDS Nurse #1 stated MDS assessment for Resident #8 's receip revealed that she had	CORRECTION 345392 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	A BUILDING 345392 B. WING BOVIDER OR SUPPLIER RO HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 medications Geodon, Ativan, Buspar, and Trazodone. Resident #8 had no physician 's orders for hypnotic medications. 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. 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, but no hypnotic medication, antianxiety medication, and antidepressant medication, but no hypnotic 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	The active care plan for Resident #8 included the focus area of the potential for adverse side effects related to the use of antipsychotic medications/antianxiety medications/antianxiety redications/antianxiety redications/antianxiety redications/antianxiety redications/antianxiety redication, and hypnotic medications/antianxiety redications/antianxiety redications/antianxiety redications/antianxiety redication, and antidepressant medication of 16/27/19 at 9:30 AM. The care plan for Resident #8 is care plan for 16/27/19 at 9:30 AM. The care plan for 16/27/19 at 9:30 AM. The care plan for Resident was reviewed with MDS Nurse #1. MDS Nurse #1. Resident #8 's physician 's orders for hypnotic medication, and antidepressant medication, but no hypnotic medication, antianxiety 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 is that be not open place of systemic observed 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 is had been completing MDS

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F 656	had always coded the Buspar and Ativan a medications and hyp MDS. She explained MDS assessment for she had also included Resident #8's psychurse #1 was asked plan had not included MDS Nurse #1 was of antipsychotic medication Resident #8's of antipsychotic medication for the facility on 10/24/included anxiety disconditional and the facility of the f	ne antianxiety medications of s both antianxiety protic medications on the d that because she coded the r hypnotic medication that ed this medication on hotropic care plan. MDS I why Resident #8 's care d antipsychotic medication. unable to explain why the use lication was not incorporated care plan. Inducted with the Director of at 10:30 AM. She indicated are plans to be son-centered, individualized, rrent status of the resident. It most recently readmitted to 18 with diagnoses that order and depression. It #12 's April 2019 physician 's luded the psychotropic (antianxiety medication) and not medication). Resident #12 orders for hypnotic It most recently readmitted to 18 with diagnoses that order and depression.	F 6	56		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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F 656	medications Buspar a had no physician 's of medication. The active care plan the focus area of the effects related to the medication/hypnotic medication. This foc 8/27/18 by MDS Nurservised on 1/30/19. An interview was corand MDS Nurse #1 and MDS Nurse #2 on Nurse #1 and MDS Nurse #12 related to psycholidicated the residen medication, hypnotic antidepressant medication, but not of reviewed with MDS Nurse #1 and Nos Nurse #1 stated MDS Nurse #1 stated MDS assessment for Resident #12's receitnat she had been cofor over 2 decades a	and Zoloft. Resident #12 orders for hypnotic for Resident #12 included potential for adverse side use of antianxiety medication/antidepressant us area was initiated on se #2 and most recently aducted with MDS Nurse #1 on 6/27/19 at 9:30 AM. MDS Jurse #2 indicated they sility of developing and The care plan for Resident otropic medication that at was on antianxiety medication, and cation was reviewed with MDS Nurse #2. Resident #12 as that indicated he was on an and antidepressant an hypnotic medication was lurse #1 and MDS Nurse #2. at that she coded the 4/19/19 at 7 of 7 hypnotics based on signt of Buspar. She revealed ampleting MDS assessments and that she had always a medications of Buspar and	F	656	(ENCY)	
	hypnotic medication that because she coor hypnotic medication this medication on Recare plan. MDS Nurs	on the MDS. She explained ded the MDS assessment for that she had also included esident #12 's psychotropic se #2 also indicated she had the antianxiety medication				

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F 656	hypnotic medication have explained why hypnotic medication. An interview was con Nursing on 6/27/19 at that she expected ca comprehensive, persand to reflect the cur. 3. Resident #20 was	ntianxiety medication and on the MDS which would the care plan included and ucted with the Director of at 10:30 AM. She indicated are plans to be son-centered, individualized, arent status of the resident.	F 6	56		
	#20 's cognition was antidepressant mediother psychotropic manufacture of Resident orders included the partition of the parti	intact. She received cation on 7 of 7 days and no nedication. #20 's active physician 's psychotropic medications pressant medication) and essant medication). for Resident #20 included a potential for adverse side use of antidepressant ty medication/hypnotic pus area was initiated by 7/17 and most recently				
	and MDS Nurse #2	on 6/27/19 at 9:30 AM. MDS Nurse #2 indicated they				

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F 656	revising care plans. #20 related to psycholindicated the resident medication, hypnotic antidepressant medic MDS Nurse #1 and M's physician 's orders antidepressant medic medication or hypnotic with MDS Nurse #1 a Nurse #2 stated that needed) order for Visic medication. She experimed to code Vistar medication and hypnomode She further explained coded Vistaril on the antianxiety medication that this was why it w's care plan as an an medication. MDS Nurse plan included an medication. An interview was con Nursing on 6/27/19 at that she expected car comprehensive, personant to reflect the current 4. Resident #45 was ad 4/26/19 with diagnose pulmonary disease (Comprehensive)	illity of developing and The care plan for Resident otropic medication that it was on antianxiety medication, and cation was reviewed with MDS Nurse #2. Resident #20 is that indicated she was on cation, but not on antianxiety ic medication was reviewed and MDS Nurse #2. MDS Resident #20 had a PRN (as itaril (antihistamine colained that she had been fil as both an antianxiety otic medication on the MDS. If that since she would 've MDS assessment as an in and hypnotic medication ras included on Resident #20 intianxiety and hypnotic inse #1 also indicated she code Vistaril as both an in and hypnotic medication ould have explained why the intianxiety and hypnotic inducted with the Director of it 10:30 AM. She indicated ire plans to be on-centered, individualized, rent status of the resident. mitted to the facility on es of chronic obstructive COPD) and dysphagia.	F	656			
	•	#45 ' s 5-day Minimum Data					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		OMPLETED
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F 656	revealed a severely resident required ex for all activities of diagnoses were pnewomit inhalation and A review of Resider plan did not reveal a for respiratory diagrand A review of Resider 5/22/2019 revealed 's room due to reside had decreased alert of 134. The Nurse Fithe resident was transpiration A review of Resider note from the hospit pm revealed the resident was transpiration. A review of Resider 6/1/19 revealed a manufactor of Resider of	reentry from the hospital impaired cognition. The stensive assistance of 1 staff aily living. The active eumonitis related to food and I COPD. It #45's comprehensive care a focus, goals or interventions nosis or dysphagia. It #45's nursing note dated she was called to the resident dent vomiting. The resident these and elevated heart rate Practitioner was notified, and insferred to the hospital. It #45's nursing readmission tall dated 5/29/2019 at 4:25 sident had pneumonia and and will continue on antibiotics. In secondary to emesis. It #45's physician order dated dechanically atered diet. Inducted with MDS Nurse #1 on 6/27/19 at 9:30 AM. MDS Nurse #2 indicated they ibility of developing and The care plan for Resident esident's recent pneumonia, phagia was reviewed with MDS Nurse #2. Both diet not know why there was no	F 6	56		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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F 656	that she expected car comprehensive, perso and to reflect the state	t 10:30 AM. She indicated re plans to be on-centered, individualized, us of the resident.		656			7/22/40
F 695 SS=D	S 483.25(i) Respirator tracheostomy care and tracheostomy care are care and tracheal succare, consistent with practice, the compreh care plan, the resider and 483.65 of this sull This REQUIREMENT by: Based on observation interviews and record administer the prescriptor and the sull than the	and tracheal suctioning. The that a resident who The including tracheostomy Stioning, is provided such The professional standards of The including tracheostomy Stioning, is provided such The professional standards of The including tracheostomy The professional standards of The including tracheostomy The including tracheostomy	F	695	F695 1. Address how corrective action will be accomplished for those residents found have been affected by the deficient practice: 1a. Resident #55 Oxygen delivery was	d to	7/23/19
	and Atrial Fibrillation. Review of Resident # 6/6/19 indicated he w rate of 2 liters per mir cannula. Resident #55's admis	55's admission orders dated as prescribed oxygen at the nute(L/Min) via nasal sion care plan dated 6/7/19 cygen therapy with the			adjusted to rate ordered by the physicial by the nurse for assigned resident. Resident #207 - Oxygen delivery was adjusted to rate ordered by the physicial 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 deficing practice: 2a. 100% of all residents receiving oxygents by tank and/or concentrator were visual	an e ng ient gen	

NAME OF PROVIDER OR SUPPLIER WADDESBORO HEALTH & REHAB CENTER WADESBORO HEALTH & REHAB CENTER WADESBORO HEALTH & REHAB CENTER WADESBORO, NC. 23170 GEOLIATORY OR LSC IDENTIFYING INFORMATION PRECLIATORY OR LSC IDENTIFYING INFORMATION PROVIDER OR SHEP CENTER SHOULD BE CROSS-REPERREDED TO THE APPROPRIATE DEFICIENCY; COMMETTED TO THE APPROPRIATE DEFICIENCY;		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		E SURVEY PLETED
MADESBORO HEALTH & REHAB CENTER WADESBORO HEALTH & REHAB CENTER WADESBORO, No. 28170 CAULTY CAULT CAULTY CAUL							С
WADESBORO HEALTH & REHAB CENTER Manual Contract Manual Contra			345392	B. WING _		06	/27/2019
WADESBORO HEALTH & REHAB CENTER (MA) ID (MA) ID (REGIONATION STATEMENT OF DEFICIENCIES TAG REQUIATORY OR LSC IDENTIFYING INFORMATION) FREETY TAG 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 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 baseing the electric oxygen at the incorrect rate of 3L/Min. His oxygen at the incorrect rate of 5L/Min. His oxygen are shall be put in place, or systemic changes made to ensure that the deficient practice will not occur: 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. at 6:25 PM, Indicate how the facility plans to monitor it's performance to make sure the	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
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FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 to receive oxygen was being delivered using the electric 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 3:20 PM, 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,	WADESBO	ORO HEALTH & REP	IAB CENTER		WADESBORO, NC 28170		
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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, 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							
oxygen amount is checked at eye level, and that any portable oxygen tanks 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, 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					_		
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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, 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					10	•	
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, correct level/amount as ordered by physician. 4. Indicate how the facility plans to monitor it's performance to make sure the							
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order was added to the MAR on 6/25/19. In an observation on 6/26/19 at 9:25 AM, 4. Indicate how the facility plans to monitor it's performance to make sure the						iered by	
In an observation on 6/26/19 at 9:25 AM, 4. Indicate how the facility plans to monitor it's performance to make sure the		, , ,			pnysician.		
In an observation on 6/26/19 at 9:25 AM, monitor it's performance to make sure the		oruer was auueu	to the WAR on 0/23/19.		4 Indicate how the facility	nlane to	
		In an observation	on 6/26/19 at 9:25 AM				
LISENDED AND WAS SUBDITED IN WIREPITAL COMMON STATEMENT					solutions are sustained:	make suit tile	
wearing portable oxygen running at the 4a. Facility DON and/or Nurse in Charge						irse in Charge	
prescribed rate of 2L/Min. He stated he wanted to will review resident's medical record and		•			-	_	
lie down in bed.		·	ZEMMI. TIC Stated He Waitled to				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	COM	E SURVEY PLETED
		345392	B. WING _			1	C / 27/2019
	ROVIDER OR SUPPLIER DRO HEALTH & REHAB	CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 051 COUNTRY CLUB ROAD VADESBORO, NC 28170	1 00	12112013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	at the incorrect rate of being delivered using concentrator. In an observation on Resident #55 was lyiful at the incorrect rate of being delivered using concentrator. In an interview on 6/3 Rehabilitation Managereceiving Occupation Therapy. She stated Resident #55's order physician indicated a range. She stated if lof breath on his preswould inform the physhis oxygen rate. In an interview on 6/3 Assistant (NA) #1 stated and the physhis oxygen at the pshe had never obsershis own oxygen rate. In an interview on 6/3 stated the aides do noxygen rate. She stated responsible for main oxygen at the prescriptions.	6/26/19 at 9:35 AM, ng in bed wearing his oxygen of 3L/Min. His oxygen was g the electric oxygen 6/26/19 at 3:10 PM, ng in bed wearing his oxygen of 3L/Min. His oxygen was g the electric oxygen 26/19 at 3:12 PM, the ger stated Resident #55 was hal, Physical and Speech therapy did not adjust red oxygen rate unless the sin oxygen administration Resident #55 appeared short cribed 2L/Min, the nurse riscian for orders to increase at at no time did the aides is oxygen rate. She stated the le for maintaining Resident prescribed rate. NA #1 stated wed Resident #55 adjusting	F	695	for oxygen 5x's/week x 2 weeks; then 3x's/week for 2 weeks then weekly for 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 the audit will be reviewed monthly for 3 months by the QAPI Committee. If discrepancies are noted, further action be implemented. 5. Date of Compliance: 07/23/2019	of	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	COMI	E SURVEY PLETED
		345392	B. WING _			C / 27/2019
	ROVIDER OR SUPPLIER DRO HEALTH & REHAB	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170		12112013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 695	Continued From pag	e 23	F 6	695		
	stated Resident #55' 2L/Min. She stated s Resident #55's adjus had received no repo oxygen delivery rate In an interview on 6/ stated it was her exp	26/19 at 3:25 PM, Nurse #1 s ordered oxygen rate was he had never observed sting his oxygen rate and she orts that he was adjusting his 26/19 at 4:10 PM, the DON sectation that Resident #55 t the prescribed rate of				
	cumulative diagnose Pulmonary Disease	nission Minimum Data Set				
	Resident #207's adn dated 6/19/19 read s 2 liters per minute (L Review of Resident s	nission physician orders the was prescribed oxygen at /Min) via nasal cannula. #207's baseline care plan ted she had a diagnosis of				
	listed her ordered ox	rd (MAR) for June 2019 ygen at 2L/Min as a notation not initialing that it was being				
	9:55 AM, Resident # her oxygen running a	d interview on 6/25/19 at 207 was lying in bed wearing at the incorrect rate of 1.5 as being delivered using the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
		345392	B. WING _			C 06/27/2019		
	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170			<u> </u>		
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 695	Continued From pag	ne 24	F 6	695				
		entrator. She voiced no						
	Resident #207 was perturbed the hall wearing port	propelling her wheelchair in able oxygen running at the						
	Resident #207 was I oxygen concentrator rate of 1.5 L/Min but across her nightstan #207 motioned that Nursing Assistant (Nursing Assistant (Nursing Assistant et al., placed the oxygen of the incorrect rate of she put Resident #200	ying in bed. Her electric was running at the incorrect her nasal cannula was lying d out of her reach. Resident she needed her oxygen. (A) #2 was obtained and n Resident #207 running at 1.5 L/Min. NA #2 stated when						
	PM read Resident #2 2L/Min as needed for	207 was to receive oxygen at r maintain an oxygen above 94%. This order was						
	Resident #207 was s wheelchair. Her port the incorrect rate of in distress or short o	6/26/19 at 3:15 PM, sitting in the hall in her able oxygen was running at 0.5L/Min. She did not appear f breath. Nurse #2 was e was adjusted to the ./Min.						
	stated she changed approximately 10 mi for 2L/Min as ordere	26/19 at 3:16 PM, Nurse #2 her portable oxygen tank nutes earlier and it was set d. She was unable to explain s running at 0.5L/Min.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345392	B. WING		C 06/27/2019
	ROVIDER OR SUPPLIER DRO HEALTH & REHAB	CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170	1 00.2172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION
F 695	stated the aides were portable oxygen and rates of portable oxygen and rates of portable oxygen concentrator. NA #4 sof the nurse. She state Resident #207 adjusts. In an interview on 6/2 stated the aides were portable oxygen and rates of portable oxygen and rates of portable oxygen and rates of portable oxygen and rates. NA #3 sof the nurse. She state	26/19 at 3:19 PM, NA #4 2 not allowed to turn on not allowed to adjust oxygen gen or electric oxygen stated it was the responsible and she had not witnessed ing her oxygen rate. 26/19 at 3:30 PM, NA #3 2 not allowed to turn on not allowed to adjust oxygen gen or electric oxygen stated it was the responsible and she had not witnessed	F 69	95	
F 700 SS=D	#2 assessed Resider wearing her portable 0.5L/Min and believe propelled in her wheel wheelchair hit the oxy stated Resident #207 adjusted so this would stated it was her expereceive her oxygen at Bedrails CFR(s): 483.25(n)(1). §483.25(n) Bed Rails The facility must attendate alternatives prior to in a bed or side rail is use correct installation, us	16/19 at 4:10 PM, the DON) stated she and Nurse at #207 after she was found oxygen at the rate of that when Resident #207 elchair, the back of her agen flow rate dial. She 's portable oxygen bag was donot occur again. The DON ectation that Resident #207 at the prescribed rate.	F 70	00	7/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		345392	B. WING _				27/2019	
NAME OF PE	ROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2772013	
WADECD	NO HEALTH & DEHAR	CENTED		205	1 COUNTRY CLUB ROAD			
WADESBO	ORO HEALTH & REHAE	CENTER		WA	ADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 700	Continued From pag	ge 26	F 7	700				
	entrapment from be	es the resident for risk of d rails prior to installation.						
	bed rails with the res	w the risks and benefits of sident or resident or resident obtain informed consent prior						
		re that the bed's dimensions he resident's size and weight.						
	recommendations a and maintaining bed	v the manufacturers' nd specifications for installing I rails. T is not met as evidenced						
	interview, the facility interventions before	side rail use and failed to se ongoing (Resident #8) for 1			F700 1. Address how corrective action will be accomplished for those residents found have been affected by this deficient	-		
	Findings included:				practice: 1a. Resident #8 - Bed rail audit comple on 6/26/2019 and bed frame was chan			
		mitted to the facility on ses of Schizo-effective and repeated falls.			to fit scoop mattress at the direction of Administrator to the Director of Nursing and Maintenance Director.			
	dated 5/10/18 revea quarterly. Interventi	t #8's Device Evaluation form led reason for evaluation was ons attempted were blank. t #8's Device Evaluation form			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	ıg		
	dated 8/2/18 revealed quarterly, the resided long term memory direceived antipsychological process of the state of the sta	ed reason for evaluation was nt was alert with short and eficit, was cooperative, tic medication, diuretic, and The resident required assisted			current residents in facility that have be rails to ensure that the bed rail assessment was completed on 6/30/20 and that bed rails are appropriate for exceptions.	119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345392	B. WING _			06/3	27/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	1 00/2	172013
				2051 COUNTRY CLUB ROAD			
WADESBO	ORO HEALTH & REHAB	CENTER	WADESBORO, NC 28170				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 700	Continued From page	e 27	F 7	700			
F 700	mobility in the bed an and wheelchair proper impaired. Side rails we positioning device. Thurse #3. Intervention none. Side rail usage and left upper and that at this time. A review of Resident were no further bed into 6/25/19. A review of Resident Data Set dated 4/12/vision was highly imposeverely impaired conception was highly imposeverely impaired conception was daily living. The active disorder and schizopole. A review of the nursing sheet for care (undate the resident had half resident #8 's care positioning. The set of Resident #8 's care positioning. The set of Resident #8 who retail the resident who reconstructed the resident who rec	d was assisted with transfer el. The resident was visually were considered a the form was signed by ons attempted to date were electermination was 1/2 right at the device was necessary #8's record revealed there ail assessments from 8/2/18 #8's quarterly Minimum 19 revealed the resident's aired. The resident had a gnition. The resident seistance for activities of we diagnoses were psychotic hrenia. Ing assistant's information ed) for Resident #8 revealed side rails constantly. In polar revealed it was updated for bed mobility and coop mattress had been in	F /	2b. Current and newly act that require bed rails will assessment scheduled a appropriateness of altern placed on the care plan a effectiveness prior to appropriate or systemic change ensure that the deficient occur: 3a. Administrator will edu Maintenance Director and Nursing (DON) regarding Guidelines and Manufact recommendations and spinstalling and maintaining 3b. 100% audit of bed rand DON for appropriateness for resident(s) with bed raplans updated appropriate resident. 4. Indicate how the facility monitor its performance to solutions are sustained: 4a. DON will audit bed raweeks per quarterly asset to ensure that bed rails compropriate and that apparternatives are identified planned prior to placing a intervention. Results of the reviewed monthly for 3 manufactors of the planned prior to placing a intervention. Results of the reviewed monthly for 3 manufactors of the planned prior to placing a intervention. Results of the reviewed monthly for 3 manufactors of the planned prior to placing a intervention. Results of the reviewed monthly for 3 manufactors of the planned prior to placing a intervention. Results of the reviewed monthly for 3 manufactors of the planned prior to placing a intervention. Results of the reviewed monthly for 3 manufactors of the planned prior to placing a intervention. Results of the planned prior to placing a intervention. Results of the planned prior to placing a intervention. Results of the planned prior to placing a intervention. Results of the planned prior to placing a intervention.	have a quarte and reviewed for natives that will as to monitor olying bed rails es will be put it es made to practice will not ucate the d Director of g the FDA tures' pecifications for g bed rails. ils completed less of interventionals with care te for the established to make sure the dails weekly x 12 essment sched continue to be ropriate a bed rail as the audit will be nonths by the discrepancies	erly or I be S. nto ot by n hat 2 dule	
	On 6/26/19 at 11:35 a	am an interview was N who stated that the		5. Date of Compliance: 0	07/23/2019		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345392	B. WING			C 06/27/2019	
NAME OF PR	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2112019
					2051 COUNTRY CLUB ROAD		
WADESBO	ORO HEALTH & REHAB	CENTER			WADESBORO, NC 28170		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 700	Continued From page	e 28	F	700			
		use the bilateral head of the					
		hold during care, and					
	reposition. The TN co	ommented that the resident					
		and uses them but could					
		The TN indicated she was					
	not familiar with a side	e raii assessment.					
	On 6/26/19 at 12:15 p	om an interview was					
		#3 who was not available.					
	On 6/26/19 at 1:25 pr	m an interview was					
		irector of Nursing (DON)					
		rentions should be attempted					
		ls, the side rail assessment					
		quarter, and the form					
	had not been done fo	The DON agreed that this					
	nad not been done to	i Nesident #0.					
	On 6/26/19 at 1:30 pr	n Resident #1's bed frame					
		r scoop mattress by the					
		sor and a completed side					
E 0.40		documented by the DON.	_	046			7/00/40
-	Resident Records - Id		F	842	2		7/23/19
SS=E	CFR(s): 483.20(f)(5),	463.70(1)(1)-(5)					
	§483.20(f)(5) Resider	nt-identifiable information.					
		elease information that is					
	resident-identifiable to						
		lease information that is					
	resident-identifiable to						
		ntract under which the agent disclose the information					
		he facility itself is permitted					
	to do so.	., F					
	§483.70(i) Medical re	cords.					
	§483.70(i)(1) In accor	dance with accepted					
	professional standard	ls and practices, the facility					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP IDENTIFICATION NUMBER: A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345392	B. WING		C 06/27/2019	
	ROVIDER OR SUPPLIER DRO HEALTH & REHAB	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170	,	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 842	that are- (i) Complete; (ii) Accurately docum (iii) Readily accessible (iv) Systematically or §483.70(i)(2) The fact all information contain regardless of the form records, except where (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pa operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purp purposes, research purp medical examiners, fa a serious threat to he by and in compliance §483.70(i)(3) The fact record information act unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirement	elented; le; and ganized cility must keep confidential med in the resident's records, m or storage method of the m release is- por their resident element, or health care ted by and in compliance si; activities, reporting of abuse, violence, health oversight diadministrative proceedings, poses, organ donation purposes, or to coroners, uneral directors, and to avert ealth or safety as permitted element with 45 CFR 164.512. cility must safeguard medical gainst loss, destruction, or I records must be retained required by State law; or me date of discharge when ent in State law; or ars after a resident reaches	F 842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345392	B. WING		C 06/27/2019	
NAME OF PE	ROVIDER OR SUPPLIER	0.0002		STREET ADDRESS, CITY, STATE, ZIP CODE	00/2//2019	
NAME OF T	TOVIDER OR OUT FEEL			2051 COUNTRY CLUB ROAD		
WADESBO	ORO HEALTH & REHAB	CENTER		WADESBORO, NC 28170		
(X4) ID PREFIX		SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	BE COMPLÉTION	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE DATE	
F 842	Continued From page 30		F 84	2		
		dical record must contain- on to identify the resident;				
	(ii) A record of the res	ident's assessments; ve plan of care and services				
	provided; (iv) The results of any	preadmission screening				
	and resident review e determinations condu					
	(v) Physician's, nurse professional's progres	's, and other licensed				
	(vi) Laboratory, radiol	ogy and other diagnostic equired under §483.50.				
	This REQUIREMENT	is not met as evidenced				
		ew and staff interview, the		F842		
		accurate social service		1 Address how corrective action will	ho	
		to psychiatric diagnoses and		1. Address how corrective action will	* *	
		ions for 5 of 5 residents		accomplished for those residents four	ind to	
		sary medications (Residents		have been affected by this deficient		
	#1, #8, #12, #20, and	#55).		practice:		
	The finalines in aluded			1a. The Social Worker will correct		
	The findings included			resident #1, #8, #12, #20,and #55 ar Saber Social Service Evaluation.	inuai	
		most recently readmitted to				
	the facility on 11/7/18	•		2. Address how corrective action will		
	included major depre	ssive disorder.		accomplished for those residents have the potential to be affected by the sa	•	
	The quarterly Minimu	` ,		deficient practice:		
		13/19 indicated Resident		2a. When a resident is due for an an		
	#20 's cognition was	intact.		Saber Social Services Evaluation by Social Worker, the Social Worker is t	aking	
		ssment completed by the		steps to assure they have the curren		
		lated 10/10/18 indicated		psychiatric-related diagnoses and cu	rrent	
		current psychiatric-related		psychoactive medications that the		
	diagnoses and was c			resident is receiving.		
	psychoactive medicat					
		mmary dated 10/10/18		Address what measures will be put	ut into	
	indicated Resident #2 Amitriptyline (antidep	20 was prescribed ressant medication) and		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 A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345392	B. WING _				C 27/2019
	ROVIDER OR SUPPLIER DRO HEALTH & REHAB	CENTER	,	20	TREET ADDRESS, CITY, STATE, ZIP CODE 051 COUNTRY CLUB ROAD VADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Duloxetine (antidepreed A social service assessed SW dated 11/16/18 in no current psychiatric currently not taking pereview of the physicial 11/16/18 indicated Research Amitriptyline and Dulocurrent psychiatric-recurrently not taking pereview of the physicial 2/5/19 indicated Research Amitriptyline and Dulocurrent psychiatric-recurrently not taking pereview of the physicial 2/5/19 indicated Research Amitriptyline and Dulocurrent psychiatric-recurrently not taking pereview of the physicial 5/3/19 indicated Research Amitriptyline and Dulocurrent psychiatric-recurrently not taking pereview of the physicial 5/3/19 indicated Research Amitriptyline and Dulocurrent psychiatric-recurrently not taking pereview of taking pereview of the physicial 5/3/19 indicated Research Amitriptyline and Dulocurrent psychiatric-recurrently not taking pereview of the physicial 5/3/19 indicated Research Amitriptyline and Dulocurrent psychiatric-recurrently not taking pereview of taking pereview of taking pereview of the physicial 5/3/19 indicated Research Amitriptyline and Dulocurrent psychiatric-recurrently not taking pereview of taking perev	ssant medication). ssment completed by the idicated Resident #20 had in-related diagnoses and was sychoactive medication. A in 's order summary dated esident #20 was prescribed exetine. ssment completed by the cated Resident #20 had no lated diagnoses and was sychoactive medication. A in 's order summary dated dent #20 was prescribed exetine. ssment completed by the cated Resident #20 had no lated diagnoses and was exetine. ssment completed by the cated Resident #20 had no lated diagnoses and was exychoactive medication. A in 's order summary dated dent #20 was prescribed	F	842	occur: 3a. Administrator will educate the Social Worker regarding accuracy of the Sabe Social Services Evaluation Annual in thareas 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 the solutions are sustained: 4a. Director of Nursing will audit all and 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 be implemented. 5. Date of Compliance: 07/23/2019	hat nual	
	Amitriptyline and Dulo An interview was con 6/26/19 at 11:15 AM. purpose of the social	ducted with the SW on The SW stated that the service assessments was to current status of the resident					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345392	B. WING _			C 06/27/2019
	ROVIDER OR SUPPLIER DRO HEALTH & REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842	10/10/18, 11/16/18, for Resident #20 that psychiatric-related of psychoactive medic SW. A review of the summaries from 10/5/3/19, and 6/11/19 had psychiatric-relat psychoactive medic social service asses SW. The SW stated Medication Administs of diagnoses list, and to complete her asses to explain why these completed inaccurar. An interview was conversely was conversely be completed accurated as the facility on 10/24/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2	al service assessments dated 2/5/19, 5/3/19, and 6/11/19 at indicated she had no diagnoses and no current ations were reviewed with the exphysician 's order 1/0/18, 11/16/18, 2/5/19, that indicated Resident #20 ted diagnoses and ations at the time of each sement were reviewed with the diagnoses and ations at the time of each sement were reviewed the tration Records, the resident 'dialked with the MDS Nurses essments. She was unable to 5 assessments were tely for Resident #20. Inducted with the Director of at 10:30 AM. She indicated ocial service assessments to ately. Is most recently readmitted to 1/18 with diagnoses that order and depression. Inducted with the Director of at 10:30 AM. She indicated ocial service assessments to ately. Inducted with the Director of at 10:30 AM. She indicated ocial service assessments to ately. Inducted with diagnoses that order and depression. Inducted a to 1/30 AM. She indicated to 1/30 AM. She indicated to currently indicated Resident is intact. Inducted with the Director of at 10:30 AM. She indicated to currently indicated by the dated 10/30/18 indicated occurrently not taking ation. A review of the summary dated 10/30/18 #12 was prescribed Buspar	F	342		

* * *	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:		IPLE CONSTRI			PLETED
	345392	B. WING _				C 27/2019
NAME OF PROVIDER OR SUPPLIER WADESBORO HEALTH & REHAB CENTER	ER	1	2051 COUN	DRESS, CITY, STATE, ZIP CODE NTRY CLUB ROAD ORO, NC 28170		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 842 Continued From page 33 (antidepressant medication) A social service assessmer SW dated 1/23/19 indicated currently not taking psychological review of the physician 's of 1/23/19 indicated Resident Buspar and Zoloft. A social service assessmer SW dated 4/18/19 indicated currently not taking psychological review of the physician 's of 4/18/19 indicated Resident Buspar and Zoloft. A social service assessmer SW dated 6/25/19 indicated Resident Buspar and Zoloft. A social service assessmer SW dated 6/25/19 indicated currently not taking psychological review of the physician 's of 6/25/19 indicated Resident Buspar and Zoloft. An interview was conducted 6/26/19 at 11:15 AM. The spurpose of the social service be up to date on the currently 10/30/18, 1/23/19, 4/18/19, Resident #12 that indicated psychiatric-related diagnosic psychoactive medications we SW. A review of the physicial summaries from 10/30/18, 1/30/18,	at completed by the displayed and completed by the displayed a	F8	342			

l` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	l \ /	(X3) DATE SURVEY COMPLETED		
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F 842	medications at the assessment were results. SW stated that she Administration Recording the Administration assessment as a completed inaccural An interview was consulted inaccural An interview was consulted as a completed accurate the American assessment as a completed accurate the American assessment dated as a consulted assessment dated as a consulted as a consulted assessment as a consulted as a	diagnoses and psychoactive cime of each social service eviewed with the SW. The reviewed the Medication ords, the resident 's talked with the MDS Nurses to esment. She was unable to assessments were stely for Resident #12. Inducted with the Director of at 10:30 AM. She indicated social service assessments to rately. admitted to the facility on uses that included anxiety enia, and psychosis. The provided with the Director of at 10:30 AM. She indicated social service assessments to rately.	F 8-	42				
	current psychiatric	related Resident #8 had no related diagnoses and was psychoactive medication. A						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345392	B. WING				C 27/2019
	ROVIDER OR SUPPLIER DRO HEALTH & REHAB			20	TREET ADDRESS, CITY, STATE, ZIP CODE 51 COUNTRY CLUB ROAD ADESBORO, NC 28170	1 06/	21/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	review of the physicia 4/10/19 indicated Res Ativan, Buspar, Geod A social service asses SW dated 6/18/19 indicurrent psychiatric-recurrently not taking pereview of the physicia 6/18/19 indicated Res Ativan, Buspar, Geod An interview was con 6/26/19 at 11:15 AM. purpose of the social be up to date on the cand to identify if there concerns. The social 1/16/19, 4/10/19, and indicated she had no diagnoses and no cur medications were revreview of the physicia 1/16/19, 4/10/19, and Resident #8 had psychoactive mesocial service assess SW. The SW stated Medication Administras diagnoses list, and to complete her asses explain why these 3 a completed inaccurate.	in 's order summary dated sident #8 was prescribed on, and Trazodone. It is sement completed by the licated Resident #8 had no ated diagnoses and was sychoactive medication. A in 's order summary dated sident #8 was prescribed on, and Trazodone. It is service assessments was to current status of the resident were any needs or service assessments dated 6/18/19 for Resident #8 that psychiatric-related rent psychoactive liewed with the SW. A in 's order summaries from 6/18/19 that indicated chiatric-related diagnoses dications at the time of each ment were reviewed with the chat she reviewed the ation Records, the resident 'stalked with the MDS Nurses is ment. She was unable to issessments were ly for Resident #8.	F	342			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		C C COMPLETED		
		345392	B. WING _			06/27/2019		
	ROVIDER OR SUPPLIER DRO HEALTH & REHA	B CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170					
(X4) ID PREFIX TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 842	4. Resident #55 wa diagnosis of Depression and read he had a psychoperession and redication. Review of Resident #55's admired he had a psychoperession and redication. Review of Resident Data Set (MDS) data cognitively intact and was coded for Depression and he would be calculated and he w	s admitted 6/6/19 with a ssion. #55's admission orders dated was prescribed Paxil ily for Depressive Disorder. Inission care plan dated 6/7/19 hiatric disorder related to eiving antidepressant #55's admission Minimum ted 6/13/19 indicated he was id exhibited no behaviors. He ression and as taking an esident #55's Care Area ed he was prescribed Paxil re planned for the ssion Social Services 7/19 under section F (Social in Status) listed a question #55's current psychiatric was coded as Resident #55 ic diagnosis and as taking no eations. #55's June 2019 Medication ord (MAR) from 6/6/19 through the received Paxil daily as	F8	42				
	Worker confirmed s Services Evaluation purpose of the Soci	he completed the Social I dated 6/7/19. She stated the al Service Evaluation was to s of Resident #55 and to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	345392		B. WING _		C 06/27/2019			
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170	•	00/21/2010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 842	The Social Worker's information regarding psychoactive mediciand the electronic management of the MDS Nurse assincorrect Social Ser 6/7/19 " must be an explain why she did accurately. In an interview on 6 of Nursing stated it social Services Evar For Diagnosis and 5. Resident #1 was 2/9/18 with diagnosis and 4 review of Resident 3/22/19 and updated interventions for cordeficit. A review of Resident 3/22/19 and updated interventions for cordeficit. A review of Resident Data Set dated 6/14 highly impaired visic impaired cognition. and no behaviors. extensive assistance locomotion, was total and personal care, a active diagnoses we dementia. The residenti-psychotic, anti-filling information of the residenti-psychotic, anti-filling information in the residenti-psychotic in t	ing any needs or concerns. Istated she received her Ing psychiatric diagnoses and Indianations from the MDS Nurses Inedical record. The Social Ivas not "clinical" therefore, Isted her. She stated the Ivice Evaluation for #55 dated Ivas not "completed Ivas not "clinical" therefore, Isted her. She stated the Ivice Evaluation for #55 dated Ivas not "completed Ivas not "completed Ivas not "clinical" therefore, Isted her. She stated the Ivice Evaluation for #55 dated Ivas not was unable to Ivas her expectation that the Ivas her expectation that	F8	342				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER DRO HEALTH & REHAB	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170		00/2//2019		
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F 842	Social Worker (SW) of Resident #1 had no of diagnoses and was of psychoactive medical. A review of the physic 6/1/19 indicated Resident (antipsychotic medical. An interview was con 6/26/19 at 11:15 AM. purpose of the social be up to date on the concerns. The social 6/12/19 for Resident psychiatric-related diapsychoactive medical. SW. A review of the 6/1/19 indicated Resident psychiatric-related diamedications at the time assessment was reviewed that she reviewed Administration Recordiagnoses list, and ta complete her assessment was reviewed that she reviewed and the time assessment was reviewed that she reviewed and the time assessment was reviewed that she reviewed and the time assessment was reviewed that she reviewed and the time assessment was reviewed that she reviewed and the time assessment was reviewed that she reviewed and the time assessment was conditionally the time and the time assessment was reviewed that she reviewed and the time assessment was conditionally the time and the t	lated 6/12/19 indicated current psychiatric-related currently not taking cion. Scian 's order summary dated dent #1 was prescribed edication) and Seroquel cition). ducted with the SW on The SW stated that the service assessments was to current status of the resident were any needs or service assessment dated #1 that indicated she had no agnoses and no current cions were reviewed with the cohysician 's order dated dent #12 had agnoses and psychoactive ne of the social service ewed with the SW. The SW wed the Medication ds, the resident 's liked with the MDS Nurses to ment. She was unable to ssment was completed lent #1. ducted with the Director of 10:30 AM. She indicated cial service assessments to rely.		342				
F 867 SS=D	QAPI/QAA Improvem	ent Activities	F 8	367		7/23/19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED		
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	ROVIDER OR SUPPLIER ORO HEALTH & REHAB	CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170			<u></u>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 867	§483.75(g)(2) The quassurance committee (ii) Develop and impleaction to correct iden This REQUIREMENT by: Based on record revresident, and staff int Assessment and Ass failed to maintain impleace following the resurvey of 4/5/18. This originally cited 4/5/18 recited on the current 6/27/19. The recited Minimum Data Set at failure of the facility or record shows a patter sustain an effective of The findings included The tag is cross referenced to code the Minimum assessment accurate (Residents #1, #8, #4 residents whose median to code the prior survet to have accurately coassessment in the arms.	ality assessment and assurance. Itality assessment and a must: Itality appropriate plans of tified quality deficiencies; Itality is not met as evidenced Itality is not met as evidenced Itality is Quality urance (QAA) Committee Itality is quality in the area of deficiency and was subsequently Itality is quality in the area of deficiency in the facility is inability to QAA Program. Itality is quality is quality in the facility failed is part of	F8	F867 1. The QAPI Process was re-eventhe Administrator and Director on 7/9/19 including the monitoring F-641. The Administrator and the following reviewed the Federal Regulation for F-641. 2. The Administrator and Direct Nursing will review the prior QA and QAPI Audits by 7/23/2019 any need for additional monitoring the QA Committee received eduthe Regional Director of Clinical related to maintaining implement procedures and follow up monit the interventions or procedures implemented in order to sustain compliance as required. 4. The Administrator and/or Director of Clinical related to maintaining implemented in order to sustain compliance as required. 4. The Administrator and/or Director of Clinical related to maintaining implemented in order to sustain complemented in order to sustain compliance as required. 4. The Administrator and/or Director of Clinical related to maintaining implemented in order to sustain complemented in order to maintain may be continued as required. 4. The Administrator and/or Director of Clinical related to maintaining implemented in order to sustain complemented in order to sustain complemented in order to maintain may be continued in order to sustain complemented in order to sustain complemented in order to sustain complemented in order to maintain may be continued in order to sustain complemented	of Nursing ing of he Director all or of API minutes to identify ing. ator and ucation by I Services inted toring of that are in the property of the property			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345392	B. WING		C 06/27/2019
	ROVIDER OR SUPPLIER DRO HEALTH & REHAB	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 867	root cause for the rep Resident Bed	am an interview was dministrator who stated the peat tag was human error.	F 86	Date of Compliance: 7/23/2019	7/23/19
SS=D	bed frames, mattress part of a regular mair areas of possible ent and mattresses are useparately from the besource that the bed resure are compatible. This REQUIREMENT by: Based on record revinterview, the facility frame to mattress siz regularly inspect bed bedframes (Resident physical environment. Findings included: Resident #8 was adm 5/23/17 with diagnost disorder, epilepsy, bifalls. A review of Resident (side rails) dated 5/10 evaluation was quarte were blank. A review of Resident (side rails) dated 8/2/	ct Regular inspection of all les, and bed rails, if any, as intenance program to identify rapment. When bed rails sed and purchased led frame, the facility must lails, mattress, and bed list. T is not met as evidenced liew, observation, and staff failed to evaluate the bed le for compatibility and to rails, mattresses and #8) for 1 of 1 reviewed for		F909 1. Address how corrective action will be accomplished for those residents four be affected by this deficient practice: 1a. Resident #8 bed rail assessment completed on 6/26/2019 and bed fram 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 have the potential to be affected by the sand 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 6/30/2 and the bed rails are appropriate for earesident. 100% bed rail equipment actions.	ne de ing ne sech

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345392	B. WING				C 06/27/2019	
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	10115211 011 001 1 21211				051 COUNTRY CLUB ROAD			
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F 909	F 909 Continued From page 41		F 9	909				
F 909	with short and long to cooperative, received diuretic, and anti-hyprequired assisted molassisted with transfer resident was visually considered a position attempted to dated with determination was 1/3 that the device was not form was signed by Now A review of the record further bed rail assess 6/25/19. A review of Resident Data Set dated 4/12/2 vision was highly imposeverely impaired cooperequired extensive as of daily living. The acceptance of the record further bed rail assess 6/25/19. Resident #8 's care positioning. The acceptance with the second repositioning. The second repositioning. The second repositioning. The second repositioning in the second repositioning. The second repositioning in the second reposition repositioning in the second repositioning in the second reposition reposition repositioning in the second reposition rep	th short and long term memory deficit, was properative, received antipsychotic, anti-anxiety, puretic, and anti-hypertensive. The resident quired assisted mobility in the bed and was assisted with transfer and wheelchair propel. The sident was visually impaired. Side rails were pusidered a positioning device. Interventions attempted to dated were none. Side rail usage extermination was 1/2 right and left upper and at the device was necessary at this time. The rem was signed by Nurse #3. The review of the record revealed there were no rether bed rail assessments from 8/2/18 to 25/19. The review of Resident #8's quarterly Minimum at Set dated 4/12/19 revealed the resident had a everely impaired cognition. The resident quired extensive assistance of 1 staff activities daily living. The active diagnoses were sychotic disorder and schizophrenia, The scoop mattress had been in		tool was performed by the Mainter Director on 7/12/2019 to ensure be dimensions, bed rails and mattress appropriate for the bed frame. 3. Address what measures will be place or systemic changes made the ensure that the deficient practice woccur: 3a. Administrator will educate the Maintenance Director and Director Nursing regarding the FDA Guideli Manufactures' recommendations as specifications for installing and maintaining bed rails. 3b. 100% audit of bed rails was completed by DON for appropriate intervention for resident(s) with be with care plans updated appropriate intervention are sustained: 4. Indicate how the facility plans to monitor it performance to make suspolution are sustained: 4a. Director of Nursing will audit be weekly x 12 weeks per quarterly assessment schedule to ensure the continues to be appropriate and the appropriate alternatives are identificare planned prior to placing a begintervention. Results of the audit weeklys of the audit of the sudit of the		nto ot and s of ls or at alls		
	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				QAPI Committee. If any discrepancies noted, further action will be implemented. Maintenance Director will perform a bi-annual audit of all bed frames, bed rand mattresses to insure appropriate for bed frame. Results will be reviewed the QAPI Committee.	ed. ails ess		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345392	B. WING _	B. WING			27/2019
	ROVIDER OR SUPPLIER DRO HEALTH & REHAB	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170			27/2013
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F 909	The MS stated he had on Resident #89's be and that the resident's area. MS did not con	le 42 le rails were not being used. d never noticed the space d frame and rail attachment s mattress did not cover this nment at this time regarding ss compared to the size of	FS	909	5. Date of Compliance: 7/23/2019		
	attachment that had a head of the bed and a noted between the ra in place and the bed	arement was made of the rail a side rail in place on the a space of 2.25 inches was il attachment with a side rail frame. Measurement of the pattress and side rail was nches.					
	who stated that there the facility with rail att The DON agreed that not properly fit in Res resulting in the space frame and was currer changing Resident #8	irector of Nursing (DON) were no other bed frames in tachments like Resident #8. t the scoop mattress does ident #8's bed frame between the mattress and					
	was observed to be omattress by MS and t	m Resident #1's bed frame changed to fit her scoop chere was no longer a seen the mattress and bed					
	yearly bedrail and fra	m an interview was tho stated he conducted a me assessment to check for , and bed mechanics. MS					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER DRO HEALTH & REHAB			S 2	STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD VADESBORO, NC 28170	UGI	2//2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 909	issues and he addres informed that there w #8 's mattress fit with rails. MS was responsed. MS commented the resident 's mattre responsible to make swhen changed. All m length with varying wiresponsible to evalua size of the bed frame mattress was too smaresident could get tracurve at end and hea mattress in place. Renot have the wire curmattress. Resident #0 Older beds have stan Resident #9 's bed framattress for a prior reused. MS stated that Resident #8 had been not match her mattres there was not an accernate was too large. MS stabed rail safety inspection was dated that he completed Reinspection and documents.	formed him about side rail seed them. MS was not as an issue with Resident a space between the side asible to make repairs of the I that the physician ordered ass type and MS was sure it fit the bed frame attresses were the same attresses were the same attresses were the was te the mattress width to the . MS commented that if a all for the bed frame the pped. MS stated the wire d of the bed held the esident #8's bed frame did we that guided the size of the esident that was an older bed. I was not sure how long an in the bed frame that does as size. MS stated that eptable space between ess and side rail. The space atted that he completed a tion annually and the last 4/2/19. MS documented esident #8's bed/rail/frame mented that they were other. MS commented that	F	909			