PRINTED: 08/05/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
JENTI IOATION NOWIDER.		A. BUILDING:		COW!! LETED		
		943561	B. WING		06/27/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WILKES R	EGIONAL MEDICAL CT	R SN	' D STREET LKESBORO, N	NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
L 006	PROVIDER OR SUPPLIER  REGIONAL MEDICAL CTR SN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		L 006	2104 © Notification to the Nursing Home Licensure and Certification Section of Division of Health Service Regulation the change of Administrator and Direc of Nursing was completed on 6/27/20 A process to ensure the ongoing compliance of .2104 © Requirements License Renewal/Change was establi on 6/28/2019. The management tean including CNO, Nurse Manager, and Charge Nurse developed and were educated on the following process: Up any management change the Nurse Manager or Charge Nurse will obtain to notification form and inform the Nursir Home Licensure and Certification Sec of the Division of Health Service Regulation of the change in leadership within twenty four hours. The CNO will	of ttor 19.  for shed n,  oon the ng stion	7/18/19
	at 1:09 PM. The CNC	·		notified of the completion of the		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 07/18/19

STATE FORM 6899 If continuation sheet 1 of 2 9TLS11

TITLE

(X6) DATE

PRINTED: 08/05/2019 FORM APPROVED

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1370 WEST D STREET  NORTH WILKES REGIONAL MEDICAL CTR SN  1370 WEST D STREET  NORTH WILKESBORO, NC 28659  10 PROVIDER'S PLAN OF CORRECTION PREFIX TAG  LOGA Continued From page 1  Administrator #1 had retired on 01/31/19 and Administrator #2 assumed the position of current Administrator and she would be happy to take the responsibility and notify the Division of Health Service Regulation of the change and could not speak to who was responsibile but again stated she would be happy to the responsibility and make the correction.  Administrator #2 was on vacation and unavailable for interview on 06/26/19 and 06/27/19 at 1:09 PM. The CNO confirmed that Nurse #1 had retired 3-5 years ago, and Nurse #2 served as the Charge Nurse of the facility on 06/27/19 at 1:09 PM. The CNO confirmed that Nurse #2 functioned as the current DON at the facility will be happy to take the responsibility and notify the Division of Health Service Regulation of the change and could not speak to who was responsibility and make the correction.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MILKES REGIONAL MEDICAL CTR SN   1370 WEST D STREET NORTH WILKESBORO, NC 28659			943561	B. WING		06/27/2019	
CAS  ID   PROVIDER'S PLAN OF CORRECTION   CASH PRECINATION   PROVIDER'S PLAN OF CORRECTION   CASH PRECINATION   PRECINATION   PRECINATION   PROVIDER'S PLAN OF CORRECTION   CASH PRECINATION   PRECI	NAME OF P	ROVIDER OR SUPPLIER			ATE, ZIP CODE		
EACH DEFICIENCY NUIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY    L 006   Continued From page 1   L 006	WILKES F	REGIONAL MEDICAL CTI	R SN		NC 28659		
Administrator #1 had retired on 01/31/19 and Administrator #2 assumed the position of current Administrator on 02/01/19. The CNO stated that the current Administrator are was on a "learning curve" and she would be happy to take the responsibility and notify the Division of Health Service Regulation of the change and could not speak to who was responsible but again stated she would be happy to the responsibility and make the correction.  Administrator #2 was on vacation and unavailable for interview on 06/26/19 and 06/27/19.  2. Review of the facility's file indicated that the Current Director of Nursing (DON) was Nurse #1.  Upon entrance to the facility on 06/26/19 at 10:00 AM the Night Charge Nurse stated that Nurse #1 had retired 3-5 years ago, and Nurse #2 served as the Charge Nurse of the facility.  An interview was conducted with the Chief Nursing Officer (CNO) of the facility on 06/27/19 at 1:09 PM. The CNO confirmed that Nurse #2 functioned as the current DON at the facility. She explained that Nurse #2 functioned as the current DON at the facility. She explained that Nurse #2 functioned as the current DON at the facility. She explained that Nurse #2 functioned as the current DON at the facility. She explained that Nurse #2 functioned as the current DON at the facility. She explained that Nurse #2 functioned as the current DON at the facility. She explained that Nurse #2 functioned as the current DON at the facility of the DON. The CNO stated she would be happy to take the responsibility and notify the Division of Health Service Regulation of the change and could not speak to who was responsible but again stated she would be happy to the responsibility and notify the Division of Health Service Regulation of the change and could not speak to who was responsible but again stated she would be happy to the responsibility and notify the Division of Health Service Regulation of the change and could not speak to who was responsible but again stated she would be happy to the responsibility and notify the Divisio	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
Nurse #2 was on vacation and unavailable for interview on 06/26/19 and 06/27/19.	L 006	Administrator #1 had Administrator #2 assist Administrator on 02/0 the current Administrator "learning curve" and state responsibility and Service Regulation of speak to who was resishe would be happy to make the correction.  Administrator #2 was for interview on 06/26 to the Administrator #2 was for interview on 06/26 to the AM the Night Charge had retired 3-5 years as the Charge Nurse An interview was con Nursing Officer (CNC) at 1:09 PM. The CNC had left the facility 3-5 functioned as the current plained that Nurse but she assumed all to DON. The CNO state take the responsibility Health Service Regul could not speak to whistated she would be hand make the correct Nurse #2 was on vac.	retired on 01/31/19 and amed the position of current of 1/19. The CNO stated that ation team was on a she would be happy to take notify the Division of Health of the change and could not sponsible but again stated to the responsibility and on vacation and unavailable of 19 and 06/27/19.  The change and could not sponsible but again stated to the responsibility and on vacation and unavailable of 19 and 06/27/19.  The change and could not sponsible but again the change and not stated that the cursing (DON) was Nurse #1 ago, and Nurse #2 served of the facility.  The change and Nurse #1 of years ago and Nurse #1 of years ago and Nurse #2 rent DON at the facility. She #2's title was charge nurse, the responsibilities of the dishe would be happy to and notify the Division of attorn of the change and no was responsible but again happy to the responsibility ion.	L 006	done by the QAPI team at least quart to ensure compliance of notification of	erly	

Division of Health Service Regulation

STATE FORM 9TLS11 If continuation sheet 2 of 2

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  WILKES REGIONAL MEDICA CTR SN    SUMMARY STATEMENT OF DEPICIENCES   177 WEST O STREET NORTH WILKESBORO, NC 28659   178 WEST O STREET NORTH WILKESBORO, NC 28659   179 WEST O STREET NORTH WILKESBORO, NC 28659   179 WEST O STREET NORTH WILKESBORO, NC 28659   174 WEST O STREET NOR	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
MILKES REGIONAL MEDICAL CTR SN   1376 WEST D STREET   NORTH WILKESBORO, NC 28659			345386	B. WING _			06/27/2019	
PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PROPRIATE   CROSS-REFERENCED TO THE APPROPRIATE   DITE			·	1370 WEST D STREET				
A recertification survey was conducted from 06/26/19 to 06/27/19. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness, Event ID AOX711 F 5655 Baseline Care Plan CFR(s): 483.21(a)(1)-(3)  §483.21 Comprehensive Person-Centered Care Planning §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-(i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-(i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	COMPLETION	
O6/26/19 to O6/27/19. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness, Event ID AOX711  F 655 Baseline Care Plan SS=D CFR(s): 483.21(a)(1)-(3)  §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a) Baseline Care Plans §483.21(a) Baseline Care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.  §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	E 000	Initial Comments		EC	000			
§483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.  §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph) (b) (c) (d) of	F 655	06/26/19 to 06/27/19. compliance with the re Emergency Prepared Baseline Care Plan	The facility was in equirements of CFR 483.73, ness, Event ID AOX711	F 6	055		7/25/19	
		§483.21 Comprehensing §483.21(a) Baseline (§483.21(a)(1) The faci implement a baseline that includes the instruction of the baseline care plate (i) Be developed within admission.  (ii) Include the minimunecessary to properly including, but not limit (A) Initial goals based (B) Physician orders.  (C) Dietary orders.  (D) Therapy services.  (E) Social services.  (F) PASARR recomm  §483.21(a)(2) The fact comprehensive care plan if the comprehensive care plan if the comprehension.  (ii) Meets the requirer (b) of this section).	Care Plans cility must develop and care plan for each resident actions needed to provide centered care of the resident all standards of quality care. In mustain 48 hours of a resident's care for a resident ted to-1 on admission orders.  The develop a colon, if applicable.  Calcility may develop a colon in place of the baseline rehensive care planain 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of					

Electronically Signed 07/18/2019

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.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345386	B. WING			06/27/2019	
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2772013
WII KES I	REGIONAL MEDICAL C	FD CN		13	370 WEST D STREET		
WILKES	REGIONAL MEDICAL C	IK SIN		N	ORTH WILKESBORO, NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC 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 655	§483.21(a)(3) The fresident and their re of the baseline care limited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services an administered by the on behalf of the facil (iv) Any updated information of the comprehensive This REQUIREMENTH by:  Based on record refacility failed to developed included minimum in provide effective per resident with an ostory that the findings included Resident #110 was a 06/17/19 with diagnor bowel status post convenience of the resident resident with an ostory available for Resident Review of a physicial routine ostomy care Empty and measure as needed.  Review of Resident Review Of Review O	acility must provide the presentative with a summary plan that includes but is not of the resident. The resident's medications and different and personnel acting ity. The promotion based on the details are care plan, as necessary. The is not met as evidenced wiew and staff interview the lop a baseline care plan that ealthcare information to son-centered care for 1 of 1 army (Resident #110).  The included perforated allectomy and colostomy.  The included detaility on the provided and colostomy.  The included perforated allectomy and colostomy.  The included detaility on the provided details are not as a needed. The included details are not allectomy and colostomy.  The included details are not as a needed. The included details are not allectomy and colostomy.  The included details are not all the included details are not allectomy and colostomy.  The included details are not all	F	655	F655 483.21 On 6/27/2019 a comprehensive plan of care for ostomy care was initiated on Resident #110. Immediate verbal in-servicing was done with the SNF sta on duty 6/27 and 6/28/2019 regarding implementation of a comprehensive plat of care for all residents. A review of current residents was performed on 6/28/2019 to confirm a comprehensive plan of care was implemented with all required elements of the individual patineeds. A process to ensure implementation of a comprehensive plat of care for newly admitted residents was implemented on 6/28/2019. A staff education plan regarding the definition, importance, and process for the comprehensive plan of care for resident will be completed by 7/25/2019. All nevesident care plans will be placed on 100% monitoring for the next 90 days to ensure timely completion, and	ff an ent an is	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345386	B. WING			06/27/2019	
NAME OF PROVIDER OR SUPPLIER  WILKES REGIONAL MEDICAL CTR SN			•	STREET ADDRESS, CITY, STATE, ZIP C 1370 WEST D STREET NORTH WILKESBORO, NC 2868			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIAT		
F 655	An interview was con Charge Nurse on 06/ Charge Nurse confirm responsible for initiatia a resident admitted to they were currently was to get the direct care care planning process responsible for the can Nurse stated that she plans based on verbaresidents active diagromission of the oston oversight on her part #110 would need and would initiate it.	ducted with the Night 27/19 at 3:26 PM. The Night and that she was ing baseline care plans when to the facility. She stated that working with the nursing staff nurses involved with the so but at this time she was are plans. The Night Charge initiated baseline care all report given and the moses. She added that the my care plan was an and confirmed that Resident costomy care plan and she	F6	random monitoring occurring an ongoing basis. The Carwill be added to the QAPI rewith data presented at least the QAPI team. The Care will be incorporated into all orientation.	re Plan procest monitoring plast of quarterly to Plan process	ess an	