PRINTED: 09/10/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345534	B. WING		C 08/08/2019
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
E 000	Initial Comments		E 000		
F 000	survey was conducte	nt ID #56T711.	F 000		
		complaint investigation was 19 through 8/8/19. Four of legations were not			
F 600 SS=G	483.12 at tag F600 a	_	F 600		8/21/19
	Exploitation The resident has the neglect, misappropriand exploitation as dincludes but is not lincorporal punishment	right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from , involuntary seclusion and nical restraint not required to nedical symptoms.			
	§483.12(a) The facili	ty must-			
	physical abuse, corp involuntary seclusion This REQUIREMEN by:			Past noncompliance: no plan of	
	and staff interview, the and to assess a resident	ne facility neglected to report dent after a fall and after the		Past noncompliance: no plan of correction required.	
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	F	TITLE	(X6) DATE

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

Electronically Signed 08/21/2019

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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345534	B. WING				08/2019
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CO	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	sampled residents re (Resident #102). Reshad complained of an assessed until the nean acute avulsion framedial malleolus (a bigament or tendon thone). Findings included: Resident #102 was a 7/22/18 with multiple glaucoma and conge The quarterly Minimu assessment dated 4/Resident #102's cogneeded extensive assessment (pain relie tablets by mouth ever for mild pain. Resident #102's care 4/14/19 and the Kard needed 1 person asses Resident #102's nurse There were no notes regarding a fall. A not (written by Nurse #2) called to the resident state resident also stated to	of ankle pain for 1 of 5 viewed for accidents sident #102 had a fall and nkle pain on 5/15/19 was not ext day and the x-ray showed cture of the inferior tip of the cone chip caused by a nat tears away a part of the dmitted to the facility on diagnoses including stive heart failure (CHF). Im Data Set (MDS) 14/19 indicated that nition was intact, and she sistance with transfers. doctor's order dated 3/20/19 ver) 325 milligrams (mgs) 2 ry 6 hours as needed (PRN)	F	600			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345534	B. WING _			C 08/08/2019	
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	 	00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From pag		F 6	500			
	she notified the doct obtained.	or and an order for x-ray was					
		report dated 5/17/18 sion fracture of the inferior tip lus".					
	(MAR) revealed that assigned to Residen	cation Administration Record Medication Aide (Med Aide), t #102, administered Tylenol ent for ankle pain on 5/15/19					
	were reviewed. The that Resident #102 v and the resident had The note dated 5/17, #102 was seen for a right ankle was done avulsion fracture of t malleolus. The residence of the following provides the following noted. Pain note further indicated edematous with severe tenderness noted to of motion was restrict were to apply immobion orthopedic for definit bearing as tolerated.	medial malleolus. The range sted due to pain. The plans bilizer per therapy, to refer to ive management, weight Tylenol and Tramadol for pr 15 minutes (min) on and					
	8:57 PM indicated the the right ankle x-ray	se's note dated 5/17/19 at at the doctor was informed of result. Orthopedic consult be resident was placed on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345534	B. WING _			C 08/08/2019	
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CO 2702 FARRELL ROAD SANFORD, NC 27330		00/00/2013	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	at all times and non-foot. The doctor also pain reliever) 50 milli as needed (PRN) for administered for compositive results. The orthopedic consthat Resident #102's with a short leg cast non-weight bearing oup appointment wou needed and to contingain. On 8/4/19 at 1:30 PN observed up in wheeled and to contingain. On 8/4/19 at 1:30 PN observed up in wheeled and to contingain. On 8/4/19 at 1:30 PN observed up in wheeled that she had a Nurse Aide (NA) assigned to wheelchair us added that she had ankle after the fall ardid not assess her at the fall. On 8/5/19 at 4:10 PN conducted with Residit was in May 2019 with bathroom. A NA from bed to the wheeled she fell onto the floot the NA that her ankle	float and to stabilize the foot weight bearing to the right o ordered Tramadol (narcotic grams (mgs) every 6 hours	F6				
	to the commode due NA went to get anoth	and up from the wheelchair to pain on her ankle. The ner NA to help her. Resident next day after the fall, the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			08/0) 08/2019	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD	<u>'</u> E	00/	30/2010	
SANFORE	HEALTH & REHABILITA	ATION CO		2702 FARRELL ROAD SANFORD, NC 27330				
(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 CO	I SHOULD BE		(X5) COMPLETION DATE	
F 600	assisted her with the the NA that her ankle On 8/6/19 at 9:45 AM Resident #102 on 5/1 NA stated that she has 5/16/19 (7-3 shift) and #102. She stated that 5/15/19 when she assibed to the wheelchair resident fell. The reson her leg. She went assisted her to get the to the wheelchair. The was fine. The NA deher she heard a "pop that around 1:30 PM, use the bathroom. To resident was unable to complaining of pain of get another NA (didn'n NA) to help her. She the resident was commankle. The NA indicated that room of Resident #10 complained of pain of informed NA #1 to let resident's complaint.	bethroom, two (2) NAs transfer and she was telling was hurting. I, NA #1, assigned to 5/19, was interviewed. The ad worked on 5/15/19 and d was assigned to Resident to the was before lunch on sisted the resident from the rusing a walker, when the ident was on the floor sitting to get help and Nurse #1 to get help and Nurse #1 to get help and Nurse #1 to resident stated that she nied that resident had told. I. NA #1 further reported the resident requested to the NA noticed that the to stand on her feet and was on her ankle, so she went to the remember the name of the then informed Nurse #1 that plaining of pain on her ted that she didn't know if the the resident and she to the head informed the 3-11 shift the fall and complained of M, NA #4 was interviewed. It she was with NA #1 in the side	F6					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345534	B. WING			C	
	NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO			STREET ADDRESS, CITY, STATE, ZIP CO 2702 FARRELL ROAD SANFORD, NC 27330	•	8/08/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 600	On 8/6/19 at 1:08 PN interviewed. The Tre went to Resident #10 wound doctor. When her day was, the resisince she had a fall treported that when snurse was aware aboresponded "yes". On 8/6/19 at 4:44 PN conducted with Nurs was assigned to Resishe worked from 7 A Nurse indicated that administration and thocasions and her streported that she did Resident #102 up from an and she was not inforwent to the resident's resident's medication already up in her whocomplain of any pain. Attempted to interviewere not available. On 8/7/19 at 9:50 AN interviewed. She state Resident #102 on 5/5 She verified that she Resident #102 on 5/5 complain of ankle pathat she didn't look/a	dn't know if the nurse had not afterwards. M, the Treatment Nurse was atment Nurse stated that she D2's room on 5/15/19 with the she asked the resident how ident responded "not good" hat morning. The nurse he asked the resident if the but the fall and the resident M, a phone interview was ee #1. She stated that she bident #102 on 5/15/19 and logoned by the she was questioned by the she corporate on several fory did not change. She not assist NA #1 in getting om the floor to the wheelchair remed about the fall. She is room to administer the last and the resident was eelchair and she did not with the PA and the doctor but	F 6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '		(X3) DATE SURVEY COMPLETED		
	345534	B. WING		C 08/08/2019		
	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	1 00/00/2013		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
not aware that Resident morning. On 8/7/19 at 10:10 A was interviewed. Sr 5/15/19 and 5/16/19 aware that Resident that she heard about was asked to intervie stated that she fell o when the NA was as to the wheelchair using the floor landing on I something "pop". On 8/7/19 at 1:30 PM (DON) was interview when she heard that fracture on her ankled unknown origin". She interviewing the staff the interview, it was origin, she found out The corporate took of the incident of the incident of the incident of the interviewed. She aware of the incident 5/17/19. She was in started the investiga #1 for not reporting the facility on 5/20/19 are and Resident #102. and after the investign neglect for not reporting the incident and not door resident and not door resident's medical resident and not door resident and not door resident's medical resident'	Internation of the state of the fall on 5/17/19 and she was the resident. The resident of a Wednesday (5/15/19) sisting her transfer from beding a walker and she fell to her knees and she heard. If the Director of Nursing red. The DON stated that Resident #102 had acute of the started the investigation by fand the resident and after not an injury of unknown that the resident had a fall over the investigation. If the Regional Consultant the stated that she was made to with Resident #102 on formed that the DON had been stated that the DON had been stated the stated the staff of the suspended Nurse #1 spation, she substantiated ting, not assessing the umenting the fall in the cords. Nurse #1 was	F 60	00			
	ROVIDER OR SUPPLIER SUMMARY S' (EACH DEFICIENC REGULATORY OR Continued From pag not aware that Resid morning. On 8/7/19 at 10:10 A was interviewed. Sh 5/15/19 and 5/16/19 aware that Resident that she heard about was asked to intervie stated that she fell of when the NA was as to the wheelchair usi the floor landing on h something "pop". On 8/7/19 at 1:30 PM (DON) was interview when she heard that fracture on her ankle unknown origin". She interviewing the staff the interview, it was origin, she found out The corporate took of the incident 5/17/19. She was in started the investigated that the investigated	A 345534 ROVIDER OR SUPPLIER DHEALTH & REHABILITATION CO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 not aware that Resident #102 had a fall that morning. On 8/7/19 at 10:10 AM, Unit Manager (UM) #2 was interviewed. She stated that she worked 5/15/19 and 5/16/19 and she was not made aware that Resident #102 had a fall. She stated that she heard about the fall on 5/17/19 and she was asked to interview the resident. The resident stated that she fell on a Wednesday (5/15/19) when the NA was assisting her transfer from bed to the wheelchair using a walker and she fell to the floor landing on her knees and she heard	ROVIDER OR SUPPLIER D HEALTH & REHABILITATION CO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 not aware that Resident #102 had a fall that morning. On 8/7/19 at 10:10 AM, Unit Manager (UM) #2 was interviewed. She stated that she worked 5/15/19 and 5/16/19 and she was not made aware that Resident #102 had a fall. She stated that she heard about the fall on 5/17/19 and she was asked to interview the resident. The resident stated that she fell on a Wednesday (5/15/19) when the NA was assisting her transfer from bed to the wheelchair using a walker and she fell to the floor landing on her knees and she heard something "pop". On 8/7/19 at 1:30 PM, the Director of Nursing (DON) was interviewed. The DON stated that when she heard that Resident #102 had acute fracture on her ankle, she reported it as "injury of unknown origin". She started the investigation by interviewing the staff and the resident and after the interview, it was not an injury of unknown origin, she found out that the resident had a fall. The corporate took over the investigation. On 8/7/19 at 1:47 PM, the Regional Consultant was interviewed. She stated that she was made aware of the incident with Resident #102 on 5/17/19. She was informed that the DON had started the investigation and had suspended NA #1 for not reporting the fall. She came to the facility on 5/20/19 and again interviewed the staff and Resident #102. She suspended Nurse #1 and after the investigation, she substantiated neglect for not reporting, not assessing the resident and not documenting the fall in the resident and NA #1 was educated on reporting	ROVIDER OR SUPPLIER DHEALTH & REHABILITATION CO SUMMARY STATEMENT OF DEFICIENCIES [EACH COFFICIENCY MUST BE PRECEDED BY FULL [EACH COFFICIENCY] Continued From page 6 not aware that Resident #102 had a fall that morning. On 8/7/19 at 10:10 AM, Unit Manager (UM) #2 was interviewed. She stated that she worked 5/15/19 and 5/16/19 and she was not made aware that Resident #102 had a fall. She stated that she heard about the fall on 5/17/19 and she was asked to interview the resident. The resident stated that she fell on a Wednesday (6/15/19) when the NA was assisting her transfer from bed to the wheelchair using a walker and she fell to the floor landing on her knees and she heard something "pop". On 8/7/19 at 1:30 PM, the Director of Nursing (DON) was interviewed. The DON stated that when she heard that Resident #102 had acute fracture on her ankle, she reported it as "injury of unknown origin". She started the investigation by interviewing the staff and the resident and after the interview, it was not an injury of unknown origin, she found out that the resident had a fall. The corporate took over the investigation on 5/17/19. She was informed that the DON had started the investigation and had suspended NA #1 for not reporting the fall. She came to the facility on 5/20/19 and again interviewed the staff and Resident #102. She suspended Nurse #1 and after the investigation, and sasessing the resident and not documenting the fall in the resident and not documenting the fall in the resident and not documenting the resident and reporting # BOULD TO		

AND DLAN OF CORRECTION IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345534	B. WING		C 08/08/2019		
	ROVIDER OR SUPPLIER HEALTH & REHABILI	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	08/08/2019		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 600	incident to the mana Consultant also indicompleted a Quality Improvement (QAP) On 8/7/19 at 4:30 P copy of the time line reviewed. The time Resident #102 had and x-ray was order acute fracture of the incident report or neevidence of a fall. F Resident #102 and 5/15/19. Interview of that upon getting out her walker, the walk balance and fell onto then to her side. The something "pop". Not assistance in helpin #1 assisted resident The conclusion of the function of the functi	ot intervene, to report the agers. The Regional cated that the DON had Assurance and Performance	F 60				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 08/08/2019
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	<u> </u>	00/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	A. Resident #102 repher foot when she fe fall was made in the Resident's pain and assessed, and findin responsible party (Rlordered and the resident and passessment were contourned to the doctor. All car MDS Nurse. The audunit Managers, Treat Assistant Director of C. All staff were educated nurse would not intermanagers), neglect a licensed nurses were protocol which include and documentation. The DON and the AD 5/17/19. D. A Quality Assurant 5/24/19 to review per investigation, all audwith the event. The continue to monitor spain assessment to the DON or her designation and pain asses the staff and pain asses the staff and pain asses the resident and pain asses the re	ported to NA #1 that she hurt all on 5/15/19. No record of resident's medical record. Skin was immediately gs were reported to the P) and the doctor. X-ray was dent was found to have a Orders for a boot, pain lic consult and ice to ankle. completed by assessing all ain. The results of the mmunicated to the RP and the plans were updated by the dit was completed by the timent Nurse and the Nursing (ADON) on 5/17/19.	F 6			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			7 55.25.			(С
		345534	B. WING _			08/	08/2019
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CO		27	REET ADDRESS, CITY, STATE, ZIP CODE 02 FARRELL ROAD ANFORD, NC 27330		
(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 600	(5/21/19) reports were allegation on the 5-da neglect. The allegation	(5/17/19) and the 5-day e provided by the DON. The ny report was resident on was substantiated, and	F	600			
	in-service on facility's assessment and doct Safe transfer. Right to be Free from CFR(s): 483.10(e)(1)	ted on 8/8/19 by staff tated that they had received Falls Protocol (reporting, umentation), Neglect, and Physical Restraints 483.12(a)(2)	F	604			8/28/19
	and dignity, including §483.10(e)(1) The rig physical or chemical of purposes of discipline	th to be free from any restraints imposed for or convenience, and not esident's medical symptoms,					
	neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to					
		y must- that the resident is free nical restraints imposed for					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		345534	B. WING	 	08/08/2019		
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	, 00.00.20.0		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 604	are not required to the symptoms. When the indicated, the facility alternative for the lead document ongoing restraints. This REQUIREMENT by: Based on observation interview, the facility (cylinder shaped cus 9 inches in diameter) Resident #105's be as a restraint and wit 2 of 3 residents revied The findings included 1. Resident #105 was the facility on 1/2/19 vascular dementia we Alzheimer's disease. The plan of care for I problem area of the resident was a read of the resident was a restraint and wit and the facility on 1/2/19 vascular dementia we have a supposed to the resident was a read of the residen	e or convenience and that eat the resident's medical e use of restraints is must use the least restrictive est amount of time and e-evaluation of the need for is not met as evidenced on, record review, and staff utilized bilateral roll guards hions 25 inches in length and on Resident #73's and ds without considering them hout a medical diagnosis for ewed for physical restraints.	F 60	·	uth of n on the n is nuse it te and were blsters he anager.		
	- Assist resident with - Anti-rollbacks to wh - Resident to have no (initiated 1/21/19) The quarterly Minimu assessment dated 4/ #105's cognition wa had no behaviors and Resident #105 was a	transfers (initiated 1/21/19) eelchair (initiated 1/21/19) on-skid socks on while in bed of Data Set (MDS) 15/19 indicated Resident as severely impaired. She d no rejection of care. assessed as requiring the of 1 with bed mobility,		were assessed on 8-19-19 by the D of Nursing and Nurse Supervisors. other bolsters were found to be in u the time of the audit. A restraint assessment will be completed prior use of bolsters for any resident who require the use. An In service was provided to the D of Nursing by the Regional Operation Manager on 8/9/19 regarding use o bolsters and restraint assessments	Director No use at to the o may Director ons of		

Facility ID: 20050005

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345534	B. WING _			C 08/08	3/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII	P CODE	1 00/00	72013
				2702 FARRELL ROAD	0022		
SANFORE	HEALTH & REHABILITA	ATION CO					
				SANFORD, NC 27330		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD B	_	(X5) COMPLETION DATE
F 604	Continued From page	e 11	F6	504			
F 604	transfers, dressing, and dependent on 1 for per required the supervision wheelchair on/off the occurred during the 7 Resident #105 was not she was only able to assistance. She had injury since her previor (1/16/19). She was an and bowel. The asser #105 had no physical A Fall Risk Assessme indicated Resident #1 score of 18 total point required a score great at high risk. The risk fall within the previous urgency/frequency of being on 2 or more his requiring assistance of mobility/transfer/ambig awareness of immedia. A nursing note comple 6/17/19 indicated Resident #10/17/19 for Resident #10/17/19/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/19/17/17/17/17/17/17/17/17/17/17/17/17/17/	and toileting. She was bersonal hygiene. She son of 1 for locomotion with a unit and walking had not aday MDS review period. So t steady on her feet and stabilize with staff two or more falls with minor ous MDS assessment lways incontinent of bladder sament indicated Resident restraints. Int completed on 4/15/19 05 was a high fall risk with a son an assessment that ter than 13 to be considered factors included having a so 6 months, elimination (bowel/bladder), gh risk medications, or supervision for ulation, and altered ate physical environment. Seted by Nurse #3 dated sident #105 was of bed and onto buttocks of a skin tear located on her rearm. Steri-strips were and no pain was noted. Se created by Nurse #3 on #105 ' s 6/17/19 fall that The report indicated that ent #105 was resting in her	F6	Service was conducted to Nursing to all licensed stappropriate use of bolster resident for use and underestraint. This in service on 8-23-19, any licensed not have the in service be allowed to work until the completed. Room rounds will be conducted a weeks by the Director Nurse Supervisors, Administrator, Busin Manager, Payroll Manager, Payroll Manager, Payroll Manager, Nactivities Director Assistant, Admissions, and Manager to observe for useds of residents, then we then monthly x 1. The Administrator will revisedly and bring the audiculation of the supervisor	aff regarding thers, assessing erstanding of was complete I nurse who did y 8-23-19 will of the in service is aducted 5x a war of Nursing, inistrator, Wouldes Office Her, Minimum Ear, Housekeepi ector and Ind/or Dietary use of bolsters weekly x 4 weekly x 4 weekly individed in the individed in the interval of the int	he ed ed ed not s eek und Data ng in eks	
	occurred at 9:30 PM. prior to the fall Reside bed. She was noted	The report indicated that					

Facility ID: 20050005

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345534	B. WING _		08/08/2019		
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		33.33.23.13	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 604	awareness and that (cylinder-shaped custoed. The incident recompleted by Unit Manager of the plan of care for risk of falls was updaintervention of bolster of the plan of care for risk of falls was updaintervention of bolster of the plan of care for risk of falls was updaintervention of bolster of the plan of the pla	dent evaluation note ent #105 had poor safety bilateral bolsters shions) were added to her eport was signed as lanager (UM) #1. Resident #105 related to the ated on 6/17/19 with the ers to her bed. ent completed on 6/24/19 e105 was a high fall risk with a ats. The risk factors included in the previous 6 months, of elimination (bowel/bladder), on 2 or more high risk ing assistance or supervision ambulation, altered diate physical environment, of understanding of one 's ove limitations.	F 6	· ·			
	dependent on 1 for to or more for personal required the extension locomotion by whee limited assistance of wheelchair off the urduring the 7-day MD	chair on the unit and the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED: `		IPLE CON	(X3) DATE SURVEY COMPLETED		
345534		B. WING			C 08/08/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2019
				2702 I	FARRELL ROAD		
SANFORE	HEALTH & REHABILITA	ATION CO		SANF	FORD, NC 27330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 604	Continued From page	e 13	F 6	604			
F 604	only able to stabilize had one fall with minor MDS assessment (4/incontinent of bladder of bowel. The assess #105 had no physical. The Nursing Assistant 7/24/19 indicated tha risk. She was noted. An observation was as room in the secured Resident #105 had but the middle third section. On 8/6/19 at 10:57 A manufacturer 's infort utilized for Resident #105 had but the middle third section. On 8/6/19 at 10:57 A manufacturer 's instrinct and yet the manufacturer is instrincted the roll gual side rails and were to rolling out of bed. The shaped and measured diameter of 9". The riby a piece of material underneath the person wide section in between the left roll guard. The	with staff assistance. She or injury since her previous 15/19). She was always and frequently incontinent sment indicated Resident restraints. It (NA) care guide dated to Resident #105 was a fall with bolsters to her bed. It conducted of Resident #105 dunit on 8/4/19 at 1:22 PM. Illateral bolsters positioned in on of her bed. M UM #1 provided the mation for the bolsters were acturer as roll guards. The facturer as roll guards. The facturer and alternative to the help high-risk persons from the roll guards were cylinder.	F	604			
	from head board. The under the roll guards the bed frame with the away from the person A second observation #105's bed on 8/6/1	ne straps were to be placed and wrapped once around e release buckles positioned					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
	345534 B. WING				C 08/08/2019	
	ROVIDER OR SUPPLIER DHEALTH & REHABILI	TATION CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330			00/00/2013
(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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 604	approximately 20" findicated in the mar roll guard covered 2 mattress leaving ap space from the bottom the mattress. An interview was coat 10:25 AM. The in Resident #105's 60 reviewed with UM #initiated the incident completed the evaluable bolsters (roll guards intervention after this bolsters were imple #105 from falling out intent of the bolsters of the mattress for the matt	(bolsters) were positioned from the top of the mattress as sufacturer's instructions. The 5" of the center portion of the proximately 34" of open om of the roll guard to the or of the roll guard to th	F6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
345534 B. WING				C 			
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CO 2702 FARRELL ROAD SANFORD, NC 27330	· ·	00/00/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 604	further explained that stopped her from fallir rolled into it. She repons the bed and Reside she would have faller indicated that Reside remove the bolsters for the secured unit and Resident #105. She was at risk for falls arget out of bed safely reported that the bilar were in place to keep out of bed. She explamoved around a lot in stopped her from fallic She reported if the boand Resident #105 rohave fallen to the group Resident #105 was in bolsters from the bed An interview was con Nursing (DON) on 8/6 bilateral bolsters (roll Resident #105 from for sustaining an injury, intervention to preven not considered the borestraint and therefore	sly fallen out of bed. She the bolsters would have ng onto the ground if she orted if the bolsters were not lent #105 rolled over too far in to the ground. NA #2 int #105 was not able to from the bed on her own. ducted with NA #3 on 8/5/19 ed she regularly worked on she was familiar with indicated that Resident #105 ind that she was unable to without assistance. NA #3 teral bolsters (roll guards) in Resident #105 in bed and that the bolsters ing off the side of the bed. bolsters were not on the bed bolled over too far she would und. NA #3 indicated that of able to remove the on her own. ducted with the Director of 6/19 at 1:45 PM. The guards) in place for reviewed with the DON. She rs were in place to keep alling out of bed and She indicated it was a safety in falls. She stated she had bolsters to be a physical e she had not completed etermine if the bilateral	Fé	504			

	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED			
	345534	B. WING		C 08/08/2019				
			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD		30/00/2019			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED T		(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
An interview was cor on 8/7/19 at 9:10 AM guards) in place for F with the MDS Nurse. that she was aware F bolsters in place to h Resident #105 was uher own. She stated get up out of bed indwould fall. She stated Resident #105 from MDS Nurse indicated voluntary movement the bolsters were to bed, so she would not the ground. She ack bolsters had on Resibed in bed. A follow up interview DON on 8/8/19 at 10 her opinion bilateral I for any resident. She the bolsters were to comattress. The DON regulations related to followed, but that she regulations and she was specific mention of be physical restraint.	ducted with the MDS Nurse The bilateral bolsters (roll Resident #105 were reviewed The MDS Nurse reported Resident #105 had bilateral er bed. She indicated that mable to get out of bed on that if Resident #105 tried to ependently she most likely d that the bolsters prevented falling onto the floor. The did that Resident #105 had in bed and that the intent of define the perimeter of the ot roll off the bed and onto nowledged that the effect the dent #105 was to keep her was conducted with the endicated that the intent of define the perimeter of the reported that she expected a physical restraints to be a had reviewed the was unable to find any olsters being considered a admitted to the facility on	F 6	04					
and contractures of le	eft and right knees.							
	SUMMARY ST (EACH DEFICIENCY REGULATORY OR Continued From page An interview was coro on 8/7/19 at 9:10 AM guards) in place for F with the MDS Nurse. that she was aware F bolsters in place to he Resident #105 was u her own. She stated get up out of bed inde would fall. She state Resident #105 from f MDS Nurse indicated voluntary movement the bolsters were to de bed, so she would not the ground. She ack bolsters had on Resided in bed. A follow up interview DON on 8/8/19 at 10 her opinion bilateral to for any resident. She the bolsters were to de mattress. The DON regulations related to followed, but that she regulations and she was specific mention of be physical restraint. 2. Resident #73 was 5/22/17 with diagnos with behavioral disturand contractures of le	ROVIDER OR SUPPLIER HEALTH & REHABILITATION CO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 An interview was conducted with the MDS Nurse on 8/7/19 at 9:10 AM. The bilateral bolsters (roll guards) in place for Resident #105 were reviewed with the MDS Nurse. The MDS Nurse reported that she was aware Resident #105 had bilateral bolsters in place to her bed. She indicated that Resident #105 was unable to get out of bed on her own. She stated that if Resident #105 tried to get up out of bed independently she most likely would fall. She stated that the bolsters prevented Resident #105 from falling onto the floor. The MDS Nurse indicated that Resident #105 had voluntary movement in bed and that the intent of the bolsters were to define the perimeter of the bed, so she would not roll off the bed and onto the ground. She acknowledged that the effect the bolsters had on Resident #105 was to keep her bed in bed. A follow up interview was conducted with the DON on 8/8/19 at 10:10 AM. She stated that in her opinion bilateral bolsters were not a restraint for any resident. She indicated that the intent of the bolsters were to define the perimeter of the mattress. The DON reported that she expected regulations related to physical restraints to be followed, but that she had reviewed the regulations and she was unable to find any specific mention of bolsters being considered a	A BUILDIN 345534 B. WING	ROUDER OR SUPPLIER THEALTH & REHABILITATION CO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 An interview was conducted with the MDS Nurse on 8/7/19 at 9:10 AM. The bilateral bolsters (roll guards) in place for Resident #105 were reviewed with the MDS Nurse reported that she was aware Resident #105 were reviewed with the MDS Nurse in place to her bed. She indicated that Resident #105 from falling not the floor. The MDS Nurse indicated that Resident #105 from falling not the floor. The MDS Nurse indicated that Resident #105 from falling not the floor. The MDS Nurse indicated that Resident #105 from falling not the floor. The MDS Nurse indicated that Resident #105 from falling not the floor. The MDS Nurse indicated that Resident #105 from falling not the floor. The MDS Nurse indicated that Resident #105 from falling not the floor. The MDS Nurse indicated that the intent of the bodsters were to define the perimeter of the bed, so she would not roll off the bed and onto the ground. She acknowledged that the effect the bolsters were to define the perimeter of the bed in bed. A follow up interview was conducted with the DON on 8/8/19 at 10:10 AM. She stated that in her opinion bilateral bolsters were not a restraint for any resident. She indicated that the intent of the bolsters were to define the perimeter of the mattress. The DON reported that she expected regulations related to physical restraints to be followed, but that she had reviewed the regulations and she was unable to find any specific mention of bolsters being considered a physical restraint. 2. Resident #73 was admitted to the facility on 5/22/17 with diagnoses that included dementia with behavioral disturbance, muscle weakness, and contractures of left and right knees.	A BUILDING 34554 B. WING CONDER OR SUPPLIER HEALTH & REHABILITATION CO SUMMARY STATEMENT OF DEFICIENCIES GEON DEFICIENCINSTS THE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 16 An interview was conducted with the MDS Nurse on 817/19 at 9:10 AM. The bilateral bolsters (roll guards) in place for Resident #105 were reviewed with the MDS Nurse. The MDS Nurse reported that she was aware Resident #105 had bilateral bolsters in place to her bed. She indicated that Resident #105 fixed to get up out of bed independently she most likely would fall. She stated that the bolsters prevented Resident #105 had voluntary movement in bed and that the intent of the bolsters were to define the perimeter of the bed, so she would not roll off the bed and onto the ground. She acknowledged that the effect the bolsters were to define the perimeter of the bed, so she would not roll off the bed and onto the ground. She acknowledged that the effect the bolsters were to define the perimeter of the mattress. The DON reported that she expected regulations related to physical restraints to be followed, but that she had reviewed the regulations and she was unable to find any specific mention of biolsters being considered a physical restraint. 2. Resident #73 was admitted to the facility on 5/22/17 with diagnoses that included dementia with behavioral disturbance, muscle weakness, and contractures of left and right knees.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345534	B. WING		08/08/2019		
	ROVIDER OR SUPPLIER DHEALTH & REHABILI	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	,		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION		
F 604	injury initiated on 5/s included, in part: - Bolsters (cylinder-stamily request to asswhen in bed (initiated Fall mat (initiated Fall Risk Assessmindicated Resident Facore of 25 total poir required a score great high risk. The rist fall within the previourgency/frequency (incontinence, being medications, requirit for mobility/transfer/awareness of immerimpulsive, and lack physical and cognition. The quarterly Minimassessment dated 7 's cognition was see behaviors and no rewas assessed as reassistance of 2 or mas dependent on 2 was dependent on 2	risk for falls and fall related 9/19. The interventions shaped cushions) to bed per sist with proper positioning at 5/9/19) 5/9/19) I non-skid footwear (initiated ansfers (initiated 5/9/19) hent completed on 6/2/19 473 was a high fall risk with a nts on an assessment that eater than 13 to be considered at factors included having one us 6 months, of elimination (bowel/bladder), on 2 or more high risk ng assistance or supervision ambulation, altered diate physical environment, of understanding of one 's ve limitations.	F 604	1			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 08/08/2019
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	•	00/00/2013
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F 604	Continued From pag	e 18	F 6	04		
	always incontinent of	bladder and bowel. The discount to the discoun				
	7/10/19 indicated that	nt (NA) care guide dated t Resident #73 was a fall with bolsters to her bed.				
	the secured unit on 8 #73 was asleep in be	conducted of Resident #73 in 1/5/19 at 3:40 PM. Resident ed and bilateral bolsters were dle third section of her bed.				
	provided the manufa bolsters utilized for F were termed by the rather than the manufacturer's indicated the roll guaside rails and were to rolling out of bed. The shaped and measured diameter of 9". The by a piece of materia underneath the person wide section in between the left roll guard. The roll guards were to be from head board. The under the roll guards	M Unit Manager (UM) #1 cturer 's information for the desident #73. These bolsters manufacturer as roll guards. instructions, dated 8/7/12, rds were an alternative to to help high-risk persons from the roll guards were cylinder and 25" in length with a roll guards were connected all that was to be positioned for when in bed leaving a 23" the instructions indicated the the placed approximately 20" the straps were to be placed and wrapped once around				
	away from the perso A second observation #73 's bed on 8/6/19 s bed was approxima roll guards (bolsters) approximately 20" from	n was conducted of Resident at 11:33 AM. Resident #73 ' ately 79" length. The bilateral				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING			C 08/08/2019
	ROVIDER OR SUPPLIER HEALTH & REHABILIT			STREET ADDRESS, CITY, ST 2702 FARRELL ROAD SANFORD, NC 27330	I	06/06/2019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	((EACH CORRECTED CROSS-REFERE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 604	roll guard covered 25 mattress leaving app space from the botto bottom the mattress. An interview was cor at 10:25 AM. She st. Resident #73 had bil on her bed. She rep a fall risk and she was safely on her own. S #73's family had reconsters to her bed a intervention. She state bolsters were to defin mattress for the resident considered the borestraint and therefor any assessment to dolsters were restraint. An interview was cor at 2:00 PM. She state the secured unit and Resident #73. She in	or of the center portion of the roximately 34" of open of the roll guard to the or of the or	F	504	SELIGIENOT)	
	reported that she bel (roll guards) were in Resident #73. She emoved around in bed have stopped her from she rolled into it. She were not on the bed too far she would have #2 indicated that Resident in the remove the bolsters.	without assistance. NA #2 ieved the bilateral bolsters place to prevent a fall for explained that Resident #73 If and that the bolsters would m falling onto the ground if the reported if the bolsters and Resident #73 rolled over the fallen to the ground. NA sident #73 was not able to from the bed on her own. Inducted with NA #3 on 8/5/19				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345534	B. WING		C 08/08/2019	
	ROVIDER OR SUPPLIER D HEALTH & REHABILIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	00/00/2019	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 604	the secured unit and Resident #73. She i was at risk for falls a get out of bed safely reported that the bila were in place to kee out of bed. She exp moved around a lot i stopped her from fall She reported if the b and Resident #73 ro have fallen to the gro Resident #73 was no from the bed on her An interview was con Nursing (DON) on 8/bilateral bolsters (rol Resident #73 were restated that the bolste Resident #73 from fa sustaining an injury intervention to preve not considered the b restraint and therefo any assessment to bolsters were restraind. An interview was con on 8/7/19 at 9:10 AM guards) in place for I with the MDS Nurses that she was aware bolsters in place to he Resident #73 was ur own. She stated that up out of bed independent.	ted she regularly worked on she was familiar with indicated that Resident #73 and that she was unable to without assistance. NA #3 teral bolsters (roll guards) to Resident #73 from falling ained that Resident #73 in bed and that the bolsters ing off the side of the bed. Tolsters were not on the bed alled over too far she would bund. NA #3 indicated that to able to remove the bolsters own. Inducted with the Director of 6/19 at 1:45 PM. The liquards) in place for eviewed with the DON. She ers were in place to keep alling out of bed and She indicated it was a safety in falls. She stated she had olsters to be a physical ore she had not completed etermine if the bilateral	F 60	14		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING		1	C 08/08/2019	
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 641 SS=E	MDS Nurse indicated voluntary movement is the bolsters were to complete bed, so she would not the ground. She acknowledge bed. A follow up interview DON on 8/8/19 at 10: her opinion bilateral befor any resident. She the bolsters were to complete bed. A follow up interview DON on 8/8/19 at 10: her opinion bilateral befor any resident. She the bolsters were to complete before any resident. She the bolsters were to complete before any resident she regulations related to followed, but that she regulations and she was specific mention of both physical restraint. Accuracy of Assessment CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on observation interview, and staff in code the Minimum Dataccurately in the area (Residents #73 and #treatments/procedure	ling onto the floor. The that Resident #73 had in bed and that the intent of lefine the perimeter of the troll off the bed and onto nowledged that the effect the dent #73 was to keep her in was conducted with the 10 AM. She stated that in holsters were not a restraint indicated that the intent of lefine the perimeter of the reported that she expected physical restraints to be had reviewed the was unable to find any olsters being considered a lents of Assessments. It accurately reflect the is not met as evidenced in, record review, resident terview, the facility failed to lata Set (MDS) assessment is of physical restraints 105), special s/programs (Residents #72 tion (Resident #17) for 5 of d.	F	F641 Minimum Data Set Assessment (MDS modifications for residents #73 and #1 were modified on 8/21/19 by the Reg Reimbursement Manager to show /us restraint section P. Resident # 113, M modification to section O was complet on 8/7/19 by the Regional Reimbursem Manager to show hospice services pri) 03 ional e of DS eed ment	8/28/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345534	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	040004	STREET ADDRESS, CITY, STATE, ZIP CODE			08/	08/2019
NAME OF PI	ROVIDER OR SUPPLIER						
SANFORD	HEALTH & REHABILITA	ATION CO			702 FARRELL ROAD		
				S	ANFORD, NC 27330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PI REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (X5 (EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 641	Continued From page 22 1. Resident #105 was most recently readmitted to the facility on 1/2/19 with diagnoses that included vascular dementia with behavioral disturbance, Alzheimer's disease, and repeated falls.			641	admission. Resident # 72, MDS modification, section 0 for use of Bipap was completed on 8/7/19 by the MDS Nurse. Resident #17 MDS modification was not needed after review on 8/8/19	by	
	The plan of care for Resident #105 included the risk of falls and indicated the intervention of bolsters (cylinder-shaped cushions) to her bed was initiated on 6/17/19. The quarterly Minimum Data Set (MDS) assessment dated 7/17/19 indicated Resident #105 's cognition was severely impaired. She had no behaviors and no rejection of care. Resident #105 was assessed as requiring the extensive assistance of 2 or more with bed mobility and transfers. Resident #105 was not steady on her feet and she was only able to stabilize with staff assistance. The assessment indicated Resident #105 had no physical restraints (defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident 's body that the individual cannot remove easily which restricts freedom of movement or normal access to one 's body).				the Regional Reimbursement Manager, resident #17 MDS was accurately coded by the Social Worker. The last comprehensive or quarterly Minimum Data Set (MDS) Assessment for all current residents was completed no later than 8/23/19. Section C was audited by the Social Worker on 8/12/19, which resulted in 7 modifications. Modifications completed on 8/14/19 by the Social Worker. All Current residents last comprehensive or quarterly assessment		
					was audited for Section O. This audit was completed by the MDS nurse and Regional Reimbursement Manager on 8/19/19. Modifications required to 1 resident for services prior to admission completed on 8/19/19 by the MDS nurse. All Current Residents last comprehension or quarterly assessment was audited for Section P related to hospice services was completed on 8/19/19 by the MDS Nurse and Regional Reimbursement Nurse.	se. ive or vas	
	s room in the secured Resident #105 had be the middle third section On 8/6/19 at 10:57 A provided the manufact bolsters utilized for R bolsters were termed	M Unit Manager (UM) #1 cturer's information for the lesident #105. These by the manufacturer as roll cturer's instructions, dated			additional residents were identified as requiring modifications. An in service was provided to the Social Worker and MDS nurse regarding accuracy of assessments on 8/14/19 by the Regional Reimbursement Manager The Regional Reimbursement Manage will audit 5 charts weekly x 4 weeks, th 2 charts weekly x 4 weeks then 1 chart monthly x 1 month for accuracy of sect C, O and P.	y r en	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345534	B. WING	B. WING		C 08/08/2019	
NAME OF PI	ROVIDER OR SUPPLIER	0.000	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	00	5/06/2019	
				2702 FARRELL ROAD			
SANFORD	HEALTH & REHABILITA	ATION CO		SANFORD, NC 27330			
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 641	Continued From page 23 alternative to side rails and were to help high-risk		F 64	41 The Administrator will review th	ne audits		
	persons from rolling of were cylinder shaped with a diameter of 9". connected by a piece positioned underneatileaving a 23" wide se guard and the left roll indicated the roll guar approximately 20" frowere to be placed underneated buckles positions. A second observation #105's bed on 8/6/19 #105's bed was appoillateral roll guards (bapproximately 20" frowindicated in the manuroll guard covered 25 mattress leaving approximately 20" frowindicated in the manuroll guard covered 25 mattress leaving approximately 20" frowindicated in the mattress. An interview was confused as a second she regularly wand she was familiar indicated that Reside and that she was unawithout assistance.	and measured 25" in length The roll guards were of material that was to be in the person when in bed ction in between the right roll guard. The instructions rds were to be placed in head board. The straps der the roll guards and if the bed frame with the ioned away from the person. It was conducted of Resident roximately 79" length. The polsters) were positioned in the top of the mattress as facturer's instructions. The if of the center portion of the roximately 34" of open in of the roll guard to the		The Administrator will review th weekly and bring the audit findi Quality Assurance Committee r months.	ings to the		
	explained that Reside bed and she thought fallen out of bed. She bolsters would have s	for Resident #105. She ent #105 moved around in the resident had previously be further explained that the stopped her from falling onto ed into it. She reported if the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER DHEALTH & REHABILIT	1.111		STREET ADDRESS, CITY, STATE, ZIP COD 2702 FARRELL ROAD SANFORD, NC 27330	•	8/08/2019	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 641	Continued From pag	e 24	F 6	41			
	rolled over too far sh ground. NA #2 indic not able to remove th her own.	the bed and Resident #105 e would have fallen to the cated that Resident #105 was ne bolsters from the bed on					
	at 3:25 PM. She stated she regularly worked on the secured unit and she was familiar with Resident #105. She indicated that Resident #105 was at risk for falls and that she was unable to get out of bed safely without assistance. NA #3 reported that the bilateral bolsters (roll guards)						
	out of bed. She expl moved around a lot i stopped her from fall She reported if the b and Resident #105 r have fallen to the gro	o Resident #105 from falling ained that Resident #105 in bed and that the bolsters ing off the side of the bed olsters were not on the bed olled over too far she would bund. NA #3 indicated that not able to remove the did not not on the own.					
	Nursing (DON) on 8/bilateral bolsters (rol Resident #105 were stated that the bolster Resident #105 from	reviewed with the DON. She ers were in place to keep falling out of bed and She indicated it was a safety					
	on 8/7/19 at 9:10 AM Resident #105 had b in place to her bed a MDS assessment. S #105 was unable to	nducted with the MDS Nurse I. The MDS Nurse confirmed vilateral bolsters (roll guards) the time of her 7/17/19 he indicated that Resident get out of bed on her own. sident #105 tried to get up					

AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345534	B. WING		C 08/08/2019		
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(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 641	fall. She stated that Resident #105 from MDS Nurse indicated voluntary movement the bolsters were to bed, so she would not the ground. She ack bolsters had on Resided in bed. The MD not considered the e Resident #105 when assessment in the air A follow up interview DON on 8/8/19 at 10 her opinion bilateral not a physical restraindicated that the integration of the perimeter reported that she expaccurately, however, regulations and she indicated	e 25 ently she most likely would the bolsters prevented falling onto the floor. The d that Resident #105 had in bed and that the intent of define the perimeter of the ot roll off the bed and onto knowledged that the effect the dent #105 was to keep her S Nurse revealed she had ffect the bolsters had on she completed the MDS rea of physical restraints. was conducted with the total AM. She stated that in bolsters (roll guards) were int for any resident. She ent of the bolsters were to of the mattress. The DON beected the MDS to be coded is he had reviewed the was unable to find any olsters being considered a	F 6	41			
	5/22/17 with diagnos with behavioral distu and contractures of I The plan of care for risk of falls and indic bolsters (cylinder-sha	Resident #73 included the ated the intervention of aped cushions) to bed per ist with proper positioning					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	 	00/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	Continued From page	e 26	F 6	41		
	's cognition was sevice behaviors and no rejument was assessed as requestion assistance of 2 or more was dependent on 2. Resident #73 was now was only able to stabe the assessment indiction physical restraints (domethod or physical or material or equipment resident 's body that remove easily which movement or normal	1/19 indicated Resident #73 erely impaired. She had no ection of care. Resident #73 uiring the extensive ore with bed mobility. She or more for transfers. t steady on her feet and she ilize with staff assistance. cated Resident #73 had no efined as any manual r mechanical device, it attached or adjacent to the the individual cannot				
	the secured unit on 8 #73 was asleep in be positioned in the mid	1/5/19 at 3:40 PM. Resident and bilateral bolsters were dle third section of her bed.				
	provided the manufactoolsters utilized for Rewere termed by the manufacturer's indicated the roll guaside rails and were to rolling out of bed. The shaped and measure diameter of 9". The manufacture of material underneath the person wide section in between the left roll guard. The roll guards were to be from head board.	M Unit Manager (UM) #1 cturer 's information for the esident #73. These bolsters manufacturer as roll guards. instructions, dated 8/7/12, rds were an alternative to behelp high-risk persons from the roll guards were cylinder and 25" in length with a roll guards were connected I that was to be positioned for when in bed leaving a 23" the instructions indicated the the placed approximately 20" the straps were to be placed and wrapped once around				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER DHEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	<u> </u>	00/00/2013	
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 641	A second observation #73 's bed on 8/6/19 s bed was approximated roll guards (bolsters)	ne release buckles positioned in. n was conducted of Resident 9 at 11:33 AM. Resident #73 'ately 79" length. The bilateral were positioned	F 6	41			
	indicated in the man roll guard covered 29 mattress leaving app	om the top of the mattress as ufacturer 's instructions. The 5" of the center portion of the proximately 34" of open of the roll guard to the					
	Assistant (NA) #2 or stated she regularly and she was familiar indicated that Reside and that she was un without assistance. believed the bilatera place to prevent a fa explained that Reside and that the bolsters from falling onto the She reported if the beand Resident #73 ro have fallen to the great state of the st	nducted with Nursing 1 8/5/19 at 2:00 PM. She worked on the secured unit 1 with Resident #73. She ent #73 was at risk for falls able to get out of bed safely NA #2 reported that she I bolsters (roll guards) were in Ill for Resident #73. She ent #73 moved around in bed would have stopped her ground if she rolled into it. olsters were not on the bed lled over too far she would bund. NA #2 indicated that of able to remove the bolsters own.					
	at 3:25 PM. She sta the secured unit and Resident #73. She i was at risk for falls a get out of bed safely	nducted with NA #3 on 8/5/19 ted she regularly worked on she was familiar with ndicated that Resident #73 nd that she was unable to without assistance. NA #3 ateral bolsters (roll guards)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345534		345534	B. WING			C 08/08/2019		
	NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO			270	EET ADDRESS, CITY, STATE, ZIP CODE 2 FARRELL ROAD NFORD, NC 27330	1 00/	06/2019	
(X4) ID PREFIX TAG			ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 641	out of bed. She explamoved around a lot in stopped her from falli She reported if the boand Resident #73 roll have fallen to the gro Resident #73 was not from the bed on her considered that the bolsters (roll Resident #73 were restated that the bolster Resident #73 from fall sustaining an injury, intervention to prever An interview was con on 8/7/19 at 9:10 AM. Resident #73 had bild bed at the time of her that Resident #73 wa her own. She stated get up out of bed indewould fall. She reporprevented Resident #floor. The MDS Nurs #73 had voluntary mointent of the bolsters of the bed, so she wo onto the ground. She effect the bolsters had keep her in bed. The had not considered the Resident #73 when s	Resident #73 from falling ained that Resident #73 in bed and that the bolsters ing off the side of the bed. Olsters were not on the bed led over too far she would und. NA #3 indicated that it able to remove the bolsters own. ducted with the Director of 6/19 at 1:45 PM. The guards) in place for eviewed with the DON. She ins were in place to keep lling out of bed and She indicated it was a safety in falls. ducted with the MDS Nurse. The MDS Nurse confirmed ateral bolsters in place to her 7/1/19 MDS. She indicated is unable to get out of bed on that if Resident #73 tried to ependently she most likely	F	541				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345534		1 ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345534	B. WING _	08/08/2019		
	ROVIDER OR SUPPLIER DHEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	00/00/2019	
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F 641	DON on 8/8/19 at 10 her opinion bilateral not a physical restraindicated that the interior define the perimeter reported that she exaccurately, however, regulations and she specific mention of bighysical restraint. 3. Resident #113 was 5/16/19 with diagnost A nursing note dated #113 was admitted to 5-day respite stay that The interim plan of Carlot Resident #113 was a respite stay under the A Physician 's Assist indicated Resident # respite stay under the transitioned to long to the 5-day respite stay under the transitioned with hospite stay under the 5-day respite stay under the transitioned to long to the 5-day respite stay under the transitioned with hospite stay under the 5-day respite stay under the 5-day respite stay under the 5-day respite stay under the transitioned to long to the 5-day respite stay under the transitioned with hospite stay under the transitioned to long to the 5-day respite stay under the transitioned to long to the 5-day respite stay under the transitioned to long to the 5-day respite stay under the transitioned to long to the 5-day respite stay under the transitioned to long to the 5-day respite stay under the transitioned to long to the 5-day respite stay under the transitioned to long to the 5-day respite stay under the transitioned to long to the 5-day respite stay under the transitioned to long to the 5-day respite stay under the transitioned to long the 5-day respite stay under the transitioned to long the 5-day respite stay under the transitioned to long the 5-day respite stay under the transitioned to long the 5-day respite stay under the transitioned to long the 5-day respite stay under the transitioned to long the 5-day respite stay under the 5-day respite stay	was conducted with the 0:10 AM. She stated that in bolsters (roll guards) were int for any resident. She ent of the bolsters were to of the mattress. The DON pected the MDS to be coded, she had reviewed the was unable to find any polsters being considered a sea that included heart failure. If 5/16/19 indicated Resident to the facility from home for a rough hospice services. Fare dated 5/16/19 indicated admitted to the facility for a e care of hospice. Itant (PA) note dated 5/21/19 in the care at the completion of y (5/21/19). Resident #113	F 6	41		

1 1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		345534	B. WING			C 08/08/2019		
	ROVIDER OR SUPPLIER D HEALTH & REHABILIT.	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330				
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F 641	He also was not iden care while a resident 14 days. The hospic sections of the 5/23/2 were completed by the An interview was coron 8/6/19 at 1:24 PM Resident #113 that he respite care while a respite care while a respite care while a respite care while as the last 14 days and received hospice care facility during the last the MDS Nurse. She coded inaccurately. #113 was on hospice admission to the facidays (from the dated assessment). She as Resident #113 was a 5/16/19 and that this on the 5/23/19 MDS, this was an oversight. An interview was corn Nursing on 8/8/19 at expected the MDS to 4. Resident # 72 was 8/25/16 with multiple Obstructive Sleep Ap Obstructive Pulmona annual Minimum Dat dated 4/1/19 indicate moderate cognitive in on BIPAP (Bilevel Police 14 days.)	itity during the last 14 days. Itified as receiving respite at the facility during the last be care and respite care 19 MDS for Resident #113 me MDS Nurse. Inducted with the MDS Nurse II. The 5/23/19 MDS for ad not indicated he received resident at the facility during had not indicated he ewhile not a resident at the tat 14 days were reviewed with the revealed the MDS was She confirmed that Resident to services prior to his lity and within the last 14 of the 5/23/19 MDS dditionally confirmed that admitted for respite care on should have been marked The MDS Nurse stated that the inducted with the Director of 10:10 AM. She stated she is be coded accurately. Is admitted to the facility on diagnoses including onea (OSA) and Chronic any Disease (COPD). The a Set (MDS) assessment	F	341				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345534	B. WING			C 08/08/2019
	ROVIDER OR SUPPLIER HEALTH & REHABILITA			STREET ADDRESS, CITY, STATE, 2702 FARRELL ROAD SANFORD, NC 27330	ZIP CODE	00/00/2019
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F 641	for BIPAP on at bedtimilliliter (mls). EPAP pressure):8 centimete of 20 and maximum pressure (maximum pressure):8 centimete of 20 and maximum pressure (maximum pressure):8 centimete of 20 and maximum pressure (maximum pressure):8 centimete (maximum pressure):9 centimete (maximum	loctor's order dated 11/12/18 me - settings for OSA, 400 (expiratory positive airway er (cm), minimum pressure pressure of 25, rate at 18. lication Administration ealed that Resident #72 was at bedtime. If, the MDS Nurse was iffied that Resident #72 was Nurse reviewed the March of that the annual MDS 1/19 was coded incorrectly s on BIPAP during the M, the Director of Nursing ed. The DON stated that S assessments to be coded	F 6	341		
	1/18/18 with diagnose disease, Hypertension. The quarterly Minimu 5/9/19 assessed the simpaired for decision short-term memory in as no for the attempt Interview for Mental States.	es that included Alzheimer's in and Diabetes. In Data Set (MDS) dated resident as being severely making with long and inpairment. She was marked to conduct the Brief Status (BIMS).				
	i ne resident's active	care plan dated 5/16/19				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
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PROVIDER OR SUPPLIER D HEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	1 33/33/23/13	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
revealed a problem due to Alzheimer's dincluded to ask yes and allow adequate A review of the Soci 5/9/19 the BIMS was due to mumbling wo On 8/6/19 at 8:45am eating breakfast. Stigood and asked if the At 3:10pm on 8/6/19 interviewed. The resimple yes and no quantity she was in pain or compared to the marked Resider attempt was made to she had attempted to the resident. The Director of Nurse 8/8/19 at 10:19am.	area of communication deficit disease. The interventions or no questions when able time for a response. al Services notes revealed on a stempted with no success, ords and confusion. a Resident #17 was observed the responded the food was his writer would like some. b Resident #17 was sident was able to answer questions, such as whether old. and during an interview with the tated it was an oversight that the first #17's 5/09/19 MDS that no occupate this interview with sing was interviewed on She stated it was her	F 64	11		
after a BIMS test ha RN 8 Hrs/7 days/Wk CFR(s): 483.35(b)(1 §483.35(b) Register §483.35(b)(1) Excep paragraph (e) or (f) of must use the service	d been attempted. k, Full Time DON)-(3) ed nurse of when waived under of this section, the facility es of a registered nurse for at	F 72	27	8/28/19	
	Continued From pagarevealed a problem due to Alzheimer's concluded to ask yes and allow adequate A review of the Soci 5/9/19 the BIMS was due to mumbling word and asked if the At 3:10pm on 8/6/19 interviewed. The resimple yes and no que to a she was in pain or concluded to a sked if the At 3:10pm on 8/6/19 interviewed. The resimple yes and no que to mumble yes and no que to mumble yes and no que to make was in pain or concluded to the resident. The Director of Nurse she marked Resider attempt was made to the resident. The Director of Nurse she had attempted to the resident. The Director of Nurse she had attempted to the resident. The Director of Nurse she had attempted to the resident. The Director of Nurse she had attempted to the resident. The Director of Nurse she had attempted to the resident. The Director of Nurse she had attempted to the resident.	ROVIDER OR SUPPLIER DHEALTH & REHABILITATION CO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 32 revealed a problem area of communication deficit due to Alzheimer's disease. The interventions included to ask yes or no questions when able and allow adequate time for a response. A review of the Social Services notes revealed on 5/9/19 the BIMS was attempted with no success, due to mumbling words and confusion. On 8/6/19 at 8:45am Resident #17 was observed eating breakfast. She responded the food was good and asked if this writer would like some. At 3:10pm on 8/6/19 Resident #17 was interviewed. The resident was able to answer simple yes and no questions, such as whether she was in pain or cold. On 8/7/19 at 9:18am during an interview with the Social Worker she stated it was an oversight that she marked Resident #17's 5/09/19 MDS that no attempt was made to conduct the BIMS, when she had attempted to complete this interview with the resident. The Director of Nursing was interviewed on 8/8/19 at 10:19am. She stated it was her expectation for the MDS to be coded correctly after a BIMS test had been attempted. RN 8 Hrs/7 days/Wk, Full Time DON	ROVIDER OR SUPPLIER D HEALTH & REHABILITATION CO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 32 revealed a problem area of communication deficit due to Alzheimer's disease. The interventions included to ask yes or no questions when able and allow adequate time for a response. A review of the Social Services notes revealed on 5/9/19 the BIMS was attempted with no success, due to mumbling words and confusion. On 8/6/19 at 8:45am Resident #17 was observed eating breakfast. She responded the food was good and asked if this writer would like some. At 3:10pm on 8/6/19 Resident #17 was interviewed. The resident was able to answer simple yes and no questions, such as whether she was in pain or cold. On 8/7/19 at 9:18am during an interview with the Social Worker she stated it was an oversight that she marked Resident #17's 5/09/19 MDS that no attempt was made to conduct the BIMS, when she had attempted to complete this interview with the resident. The Director of Nursing was interviewed on 8/8/19 at 10:19am. She stated it was her expectation for the MDS to be coded correctly after a BIMS test had been attempted. The Director of Nursing was interviewed on 8/8/19 at 10:19am. She stated it was her expectation for the MDS to be coded correctly after a BIMS test had been attempted. ROVER 12. A BIMS test had been attempted. ROVER 12. A BIMS test had been attempted. ROVER 13. A BIMS test had been attempted. ROVER 14. A BIMS test had been attempted. ROVER 15. A BIMS test had been attempted. ROVER 16. A BIMS TEST TEST TEST TEST TEST TEST TES	ROYIDER OR SUPPLIER D HEALTH & REHABILITATION CO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYMING INFORMATION) Continued From page 32 revealed a problem area of communication deficit due to Alzheimer's disease. The intervience intervience intervience and allow adequate time for a response. A review of the Social Services notes revealed on 5/9/19 the BIMS was attempted with no success, due to mumbling words and confusion. On 8/6/19 at 8:45am Resident #17 was observed eating breakfast. She responded the food was good and asked if this writer would like some. At 3:10pm on 8/6/19 Resident #17 was interviewed. The resident was able to answer simple yes and no questions, such as whether she was in pain or cold. On 8/7/19 at 9:18am during an interview with the Social Worker she stated it was an oversight that she marked Resident #17's 5/09/19 MDS that no attempt was made to conduct the BIMS, when she had attempted to complete this interview with the resident. The Director of Nursing was interviewed on 8/8/19 at 10:19am. She stated it was her expectation for the MDS to be coded correctly after a BIMS test had been attempted. RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1):23) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at	

PRINTED: 09/10/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING				08/2019
NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO			•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 702 FARRELL ROAD ANFORD, NC 27330		
(X4) ID PREFIX TAG			ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 727	must designate a reg director of nursing on \$483.35(b)(3) The dir as a charge nurse on average daily occupa This REQUIREMENT by: Based on record rev facility failed to have at least 8 consecutive for 2 of 45 days revie Findings included: The nursing staff schwere reviewed for the staff schedule had lis 6/29/19 and 6/30/19. Review of the time sh did not work on 6/29/ On 8/7/19 at 1:45 PM Resources (HR) staff She stated that she resheets for 6/29/19 and worked that day. She (an RN) had worked the Payroll/HR staff didn't know that the fat at least 8 consecutive week. On 8/7/19 at 3:20 PM reported that she had	when waived under If this section, the facility istered nurse to serve as the a full time basis. ector of nursing may serve ly when the facility has an ncy of 60 or fewer residents. Is not met as evidenced lew and staff interview, the a registered nurse (RN) for the hours a day, 7 days a week wed (6/29/19 and 6/30/19). edule and the staff posting the last 6 weeks. The nursing the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing the last 6 weeks are the last 6 weeks. The nursing	F	727	F727 The Regional Operations Manager in serviced the Director of Nursing on 8/7 regarding the Registered Nurse consecutive 8 hours a day seven day a week regulation. The Registered Nurse coverage was adjusted on 8/8/19 to validate 7 day a week coverage with 8 consecutive hou a day. The Director of Nursing will review daily the next day schedule to ensure 8 hour of Registered Nurse coverage is addressed. The Weekend coverage of the Registered Nurse will be reviewed prior to the weekend. In the event of a out, another Registered Nurse will cove the 8 hours of coverage, to include the use of the Regional Registered Nurses The Administrator or Director of Nursing will review daily, time cards of the Registered Nurses from the day before on Mondays following a weekend to ensure 8 hours of coverage was sustained. This will be done 5x/week x weeks then 3x/week x 2 weeks, then weekly x 2 weeks then monthly x 1 monthe Director of Nursing will audit the scheduled Registered Nurse coverage	rs y rs f call er g or t t t t t t t t t t t t t t t t t t	

PRINTED: 09/10/2019 FORM APPROVED OMB NO. 0938-0391

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '			(X3) DATE SURVEY COMPLETED	
		345534	B. WING			C 08/08/2019	
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		3070072013	
(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		N SHOULD BE COMPLIED DATE OF COMPLIENTS DATE DATE		
F 727	Continued From page 34 hours of RN coverage for 6/30/19. She further		F 7	5x/week x 4 weeks, then 3x/week			
	had called out.	scheduled for that weekend		weeks, then weekly x 2 weeks, the monthly x 1 month. The Administreview the audit results and presented the Outlite Assurance.	trator will ent the		
	was on call the weeks She had tried to call s staffing agency and s come on 6/29/19. Sh came to help for 3.5 h Manager reported tha	, Unit Manager #1 (a se (LPN)) reported that she end of 6/29/19 and 6/30/19. several RNs and even the he could not find an RN to e added that Nurse #4 nours on 6/30/19. The Unit at the Director of Nursing ble that weekend, she was		findings to the Quality Assurance Committee monthly x 3 months.			
	that the facility had di at the facility due to it	, the Administrator reported fficulty in hiring RNs to work s location. He added that he it on how to apply for a					
	(DON) was interviewe	M, the Director of Nursing ed. The DON stated that ulation be followed for the					
	Posted Nurse Staffing CFR(s): 483.35(g)(1)		F 7	32		8/28/19	
	must post the followir basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categ	equirements. The facility of information on a daily and the actual hours worked gories of licensed and aff directly responsible for					

Facility ID: 20050005

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345534	345534 B. WING			C 08/08/2019	
	ROVIDER OR SUPPLIER HEALTH & REHABILITA			STREET ADDRESS, CITY, STATE, ZIP COD 2702 FARRELL ROAD SANFORD, NC 27330		0/00/2019	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 732	(C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must prospecified in paragraphy daily basis at the begotial parameter plants and readabholds. Clear and readabholds and visitors (A) Clear and readabholds and visitors (B) In a prominent plants and visitors (S483.35(g)(3) Public staffing data. The fact written request, make available to the public exceed the communit (S483.35(g)(4) Facility requirements. The fact posted daily nurse states are greater. This REQUIREMENT by: Based on record revinterview, the facility staffing information and Registered Nurse (RI (6/29/19 and 6/30/19). Findings included: The nursing staff schewere reviewed for the control of the contro	Inurses or licensed of defined under State law). des. g requirements. g	F 7	F732 F732 The Daily Facility Posting for 6/30/19 were corrected on 8/8 front office receptionist. The Regional Operations Mai serviced the Director of Nursi scheduler and front office rec maintaining accuracy of the Desting. The Director of Nursi serviced the Nursing Supervise Supervised the Nursing Supervised the Nursing Supervised Superv	8/19 by the nager in ng, staffing eptionist on Daily Facility sing in		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345534	B. WING		C 08/08/2019		
NAME OF PROVIDER OR SUPPLIER			<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	06/2019	
				2702 FARRELL ROAD			
SANFORD	HEALTH & REHABILITA	ATION CO		SANFORD, NC 27330			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) BY TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		3E	(X5) COMPLETION DATE			
F 732	Continued From page	e 36	F 73	32			
	an RN for 8 hours on	The staff posting had listed 6/29/19 and 6/30/19.		8/19/19, on reflection of accurate post of Registered Nurse hours. The daily sposting will be reviewed by the Nurse Supervisor, Director of Nursing or the	staff		
	did not work on 6/29/	19 and 6/30/19.		Administrator for weekends. The Director of Nursing will compare to	dministrator for weekends.		
	She stated that she resheets for 6/29/19 an worked that day. She (an RN) had worked of the control of the contr	member was interviewed. eviewed the nurses' time d there was no RN who e also reported that Nurse #4 on 6/30/19 for 3.5 hours. I, the Regional Consultant I verified that there was no o/19 and there was only 3.5 e for 6/30/19. She further scheduled for that weekend		cards to the Daily Posting, each morni 5x/week x 4 weeks, then 3x/week x 2 weeks, then weekly x 2 weeks, then monthly x 1 month. The Director of Nursing will review the results and present the findings to the Quality Assurance Committee monthly months.	ng,		
F 758 SS=D	RN supervisor was restaff posting on the wood on 8/8/19 at 10:14 AI (DON) was interviewed she expected the staff Free from Unnec Psy CFR(s): 483.45(c)(3)(s) §483.45(e) Psychotrol §483.45(c)(3) A psychological psy	esponsible in updating the eekends. M, the Director of Nursing ed. The DON stated that if posting to be accurate. chotropic Meds/PRN Use (e)(1)-(5)	F 75	58		8/28/19	
	processes and behav	s associated with mental rior. These drugs include, drugs in the following					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345534	B. WING		C 08/08/2019	
NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		1 0010012010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 758	(ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compre resident, the facility \$483.45(e)(1) Reside psychotropic drugs unless the medication specific condition as in the clinical record \$483.45(e)(2) Reside drugs receive gradule behavioral intervent contraindicated, in a drugs; \$483.45(e)(3) Reside psychotropic drugs unless that medicated in the clinical record \$483.45(e)(4) PRN are limited to 14 day \$483.45(e)(5), if the prescribing practition appropriate for the Febeyond 14 days, he rationale in the reside indicate the duration \$483.45(e)(5) PRN drugs are limited to renewed unless the	thensive assessment of a must ensure that— lents who have not used are not given these drugs on is necessary to treat a diagnosed and documented; lents who use psychotropic al dose reductions, and ions, unless clinically an effort to discontinue these lents do not receive pursuant to a PRN order on is necessary to treat a condition that is documented; and lorders for psychotropic drugs is except as provided in attending physician or ner believes that it is PRN order to be extended or she should document their dent's medical record and	F 75	8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		345534	B. WING	B. WING		C 08/08/2019	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD		00/00/2019	
				2702 FARRELL ROAD			
SANFORE	HEALTH & REHABILIT	ATION CO		SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
				DEFICIENCI	,		
F 758	Continued From page 38		F 75	58			
	the appropriateness of that medication.						
		T is not met as evidenced					
	by: Based on record rev	riew and staff interview, the		F758			
		a documented indication or a		For resident #213, an order	was obtained		
	1	he use of the antipsychotic		on 8/7/19 to clarify the diagn			
	I .	sampled residents reviewed		Seroquel, diagnosis being de			
	I .	dications (Resident # 213).		behaviors.			
		,		All in house residents on ant	ipsychotic		
	Findings included:			medications were audited or diagnosis or rationale for use			
	Resident #213 was a	admitted to the facility from		Director of Nursing and Nurs	•		
	the hospital on 7/17/	19 with multiple diagnoses		Supervisors. Any resident w	/ho did not		
	including dementia,	Alzheimer's Disease and left		have a diagnosis, was review			
	hip intertrochanteric	fracture. The admission		Physician Assistant, Psychia	tric Nurse		
	Minimum Data Set (N	MDS) assessment dated		Practitioner, or Primary Med	ical Doctor for		
	7/24/19 indicated that			use indication/rationale. 3 of	25 residents		
		mpairment and she had		required a clarification of use	e based on		
	1	hotic medication for 7 days		diagnosis.			
	during the assessme	ent period.		An In service was provided to Regional Clinical Manager to	-		
	I .	sment (CAA) dated 7/25/19		of Nursing and Nursing Supe			
		nt #213 had diagnoses of		8/8/19 to ensure that all antip			
		s Alzheimer's disease with a		medications had a diagnosis			
	_	d the resident was receiving		for the indications of use. The			
		ressant medication) and		Nursing in serviced all licens			
	Seroquel (an antipsy	chotic medication).		the diagnosis and rationale in antipsychotic medications, w			
	Review of Resident	#213's medical records		completion date of 8/23/19.			
		physical dated 7/15/19, and		staff will be allowed to work			
		ummary dated 7/17/19		is completed. All antipsychot			
		nted indication/rationale for		reviewed by the licensed nur			
	the use of the Seroq			second check completed by			
				Supervisor or Director of Nui			
	Resident #213 had a	doctor's order dated 7/17/19		ensure appropriate use, to ir	-		
		grams (mgs) in AM and 50		diagnosis, with each order w			
	mgs in the evening for	or dementia.		The Director of Nursing and			
				Supervisors will review order			
	The Physician Assist	ant (PA) progress note dated		antipsychotic medications ar	nd		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345534	B. WING		08/08/2019	
NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		1 00/00/2013	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 758	the hospital after a finacture. The resider reduction and internal assessment and plath Aricept, Namenda a dementia. On 8/7/19 at 10:33 A assigned to Resident behaviors. On 8/7/19 at 10:35 A Resident #213, was stated that Resident problems. The Nurs resident was on Serio (DON) was interview would review Resides search for the indicated 12:05 PM, the DON find any documented use of the Seroquel records. She report facility (name of the the resident resided the facility indicated behaviors and hallus stated that she had written a clarification DON also reported the psychiatric evaluation. On 8/7/19, Resident Seroquel 25 mgs in the sero	all with left intertrochanteric int underwent left hip open all fixation (ORIF). The in included to continue ind Seroquel for Alzheimer's at #213, was interviewed. She #213 did not have any at #213 had no behavioral it is also indicated that the oquel for dementia. AM, the Director of Nursing it is also indicated that she ent #213's medical records to attion of the Seroquel. At reported that she could not did indication/rationale for the in the resident's medical ed that she had called the assisted living facility) where before the hospitalization and that the resident had contains. The DON further called the doctor and she had a order for the Seroquel. The hat she would request a	F 758	indication/rationale 5x/week x 4 we then 3x week x 2 weeks, then week weeks then monthly x 1 month. The Director of Nursing will review findings of these audits and presen findings to the Quality Assurance Committee monthly x 3 months.	kly x 2 the	

Facility ID: 20050005

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345534		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		B. WING			C 08/08/2019		
NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO			•	STREET ADDRESS, CITY, STATE, ZIP CO 2702 FARRELL ROAD SANFORD, NC 27330		0/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 758	Continued From page Attempted to interview Physician Assistant (I On 8/8/19 at 10:14 Al interviewed. She state	w the doctor and the PA) but were not available. M, the DON was again ted that she expected all ions to have a documented					