PRINTED: 11/27/2019 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG	(X	COMPLETED
		345115	B. WING			10/18/2019
	ROVIDER OR SUPPLIER	URY		STREET ADDRESS, CITY, STATE 635 STATESVILLE BOULEVAR SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
E 036 SS=C	CFR(s): 483.73(d)  (d) Training and testidevelop and maintain preparedness trainin based on the emerge paragraph (a) of this paragraph (a) (1) of the procedures at paragraph the communication paragraph (a) the training be reviewed and upon the training that is base forth in paragraph (a) assessment at paragraph (b) of this testing program must least annually. The long requirements for evan \$483.470(h).  *[For ESRD Facilities testing, and orientation program the testing, and orientation program the testing, risk assessing this section, policies (b) of this section, and paragraph (c) of this	ng. The [facility] must n an emergency g and testing program that is ency plan set forth in section, risk assessment at his section, policies and raph (b) of this section, and han at paragraph (c) of this g and testing program must lated at least annually.  3.475(d):] Training and must develop and maintain redness training and testing d on the emergency plan set ) of this section, risk graph (a)(1) of this section, res at paragraph (b) of this munication plan at section. The training and t be reviewed and updated at CF/IID must meet the cuation drills and training at  s at §494.62(d):] Training, on. The dialysis facility must n an emergency g, testing and patient that is based on the forth in paragraph (a) of this ment at paragraph (b) of this ment at paragraph (c) of this ment at paragraph (d) of this	E	036		11/15/19
ARORATORY I	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	DE	TITI F		(X6) DATE

Electronically Signed 11/08/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345115	B. WING			C <b>18/2019</b>	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2010	
ACCOPDI	US HEALTH AT SALISBU	IDV		635 STATESVILLE BOULEVARD			
ACCORDI	US REALITI AT SALISBO			SALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 036	Continued From page	÷ 1	E 03	6			
	This REQUIREMENT	is not met as evidenced					
	facility failed to develor emergency prepared facility staff.	ew and staff interviews, the op and maintain an annual ness training program for		POC for E036 An emergency preparedness training program calendar for the next 12 monwas implemented on 11/1/19. Administrator reviewed the past 12	ths		
	Findings included:			months of Maintenance related In-Services on 11/7/19 to identify any			
	manual was conducted manual did not include testing of the emerge the facility staff.  An interview was condirector on 10/17/201 reported the facility has (fire and tornado drills)	ducted with the maintenance at 6:45 PM and he ad drills over the past year so, but there was no specific on training program in place		months that did not have a facility wid training program initiated.  Maintenance Director and/or Assistan Maintenance Director will conduct a mandatory biannual emergency preparedness training for facility staff. active staff will sign an attendance she that they attended and understand who do during that emergency.  The Maintenance Director and/or Assistant maintenance director will re	t All eet at to		
	to explain the staff we various subjects during	aintenance director went on ere given information on ng the quarterly drills, but the oped an annual emergency rogram.		all findings to the QAPI meeting.  The Maintenance Director and/or Assistant Maintenance Director is responsible for implementing the			
F 637 SS=D	at 6:45 PM and she re Administrator had dev preparation plan and was not an annual tra	veloped the emergency she was not aware there ining program established. ssment After Signifcant Chg	F 63	acceptable plan of correction.		11/15/19	
	determines, or should there has been a sign	nin 14 days after the facility I have determined, that ifficant change in the mental condition. (For					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		OMPLETED
		345115	B. WING _			C 10/18/2019
	ROVIDER OR SUPPLIER  US HEALTH AT SALISB	URY		STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION OF THE APPROVING ACTION OF THE APPROVING ACTION OF THE APPROVING ACT	OULD BE	(X5) COMPLETION DATE
F 637	means a major declir resident's status that itself without further i implementing standa interventions, that ha one area of the resid requires interdisciplir care plan, or both.) This REQUIREMENT by:  Based on record revinterviews, the facility significant change in (MDS) assessment wresident fell and sust residents reviewed for Findings included:  Resident #55 had be diagnoses including vascular disease and Resident #55's admis indicated she was consupervision with bed been independent wind used a walker.  Facility documentation Resident #55's Quart Microtured her right hip Resident #55's Quart Microtured extensive as transfers and locomora wheelchair.  On 10/15/19 at 10:26 conducted with Resident medical incomplete in the side originally been admit	on, a "significant change" the or improvement in the will not normally resolve intervention by staff or by and disease-related clinical is an impact on more than ent's health status, and eary review or revision of the  ary review or revision of the  status minimum Data Set within 14 days after the ained a hip fracture for 1 of 9 or accidents (Resident #55).  The admitted 7/11/19 with diabetes, arthritis, peripheral anxiety. The admitted The analysis of the second mobility and transfers, had the walking and locomotion, and dated 7/26/19 indicated stained a fall and had	F 6	POC for F637 A complete audit of Resident #55 was completed, and corrections in 11/8/19. A review of all current residents the had a fall with fracture within the limonths was completed by the Dir Nursing on 11/7/19 to identify that significant change in status MDS assessment has been completed 14 days of the incident. The regional MDS nurse educate MDS department on correctly consignificant change when related to with fracture on 10/17/19. The regional MDS nurse will audit J for falls with fracture to identify a been coded with a significant change when related to with a significant change with a significant	made by mat have last 6 rector of t a  within d the ding a o a fall it Section all have inge. An nes 4 onths. cess will ds and ordinator valuate ons to	

Facility ID: 953007

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	СОМ	E SURVEY PLETED
		345115	B. WING			C / <b>18/2019</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144	1 10	110/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 637	knee scooter to get a fallen since being adn her hip and had surgh had continued with the walk and had to use a continued with the walk and had to use a conducted. The was conducted. The was conducted. The was conducted with had been independent scooter when she fell a wheelchair because the leg with the hip reconducted with MDS Resident #55 had a conducted with MDS Resident #55 had a conducted with hip. She further state and out of the hospital significant change in should have been concesident's fall with fra since the completion admission MDS but it on 10/17/19 at 3:08 If Administrator was constated it would be held conduct significant check when the conduct significant check was a fall with fra since the completion admission MDS but it on 10/17/19 at 3:08 If Administrator was constated it would be held conduct significant check.	round. She stated she had mitted to the facility, broke ery. She explained that she erapy but was still unable to a wheelchair to get around.  AM an interview with the ector of Nursing (ADON) ADON stated Resident #55 at with mobility with a knee and now required the use of e she cannot bear weight on epair.  M an interview was nurse #1. She stated lecline in her abilities since facility due to the fractured d Resident #55 had been in al several times and a status MDS assessment expleted to reflect the cture and multiple declines of the resident's 07/18/19 thad been overlooked.  PM an interview with the inducted. The Administrator rexpectation that staff would	F 63	MDS will be responsible for implem the acceptable plan of correction.	enting	
F 641 SS=D	§483.20(g) Accuracy		F 64	1		11/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER:  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345115	B. WING			10/1	) 18/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		107	10/2010
				635 STATESVILLE BOULEVARD			
ACCORDI	US HEALTH AT SALISBU	JRY		SALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	<b>I</b>	(X5) COMPLETION DATE
F 641	Continued From page		F 64	11			
	by: Based on staff interv hospital record review accurately code the Massessment to indica falls and the routine umedication for 1 of 3 Accidents (Resident # The findings included 1) Resident #119 was 9/21/17 with re-entry cumulative diagnoses disease, schizophren A review of Resident Data Set (MDS) asseconducted. Section 3 reported Resident #1 falls since the prior as Review of a Fall Incid 11:10 AM revealed Runwitnessed fall to the 9/1/19. She was obslaceration and hemather right wrist appear resident was transfer her injuries. A review Department notes daresident had experier her right ulna (the thir bones in the forearm)	ws, the facility failed to Minimum Data Set (MDS) te a resident 's history of use of an antipsychotic residents reviewed for #119).  admitted to the facility on 6/24/18 from a hospital. Her included Parkinson 's ia, and difficulty in walking.  #119 's quarterly Minimum ssment dated 8/13/19 was of the MDS assessment of the MDS assessment seessment.  #19 did not experience any seessment.  #19 experienced an efloor in her room on erved by the nurse to have a soma above her right eye and ed to be bruised. The red to the hospital related to a for the hospital Emergency ted 9/1/19 reveals the need a fall with a fracture of oner and longer of the two and radius (the thicker and nes in the forearm). She		POC for F641 A complete audit of Resident 119 was completed, and corrections 10/18/19. A review of all residents that have history of falls and the routine us antipsychotic medications to ide the MDS assessment was accur coded for history of falls and the use of an antipsychotic medicatic completed by the Director of Nut Unit Managers on 11/8/19. The regional MDS nurse educat MDS department on 10/17/19 reaccurately coding MDS assessmistory of falls and the routine us antipsychotic medication. The regional MDS nurse will aud J for falls and Section N for antipmedications. A minimum of 5 perfor 4 weeks and then 5 per montmonths. Data obtained from the audit probe analyzed for patterns and trereported to QAPI by the MDS comonthly times 3 months. At that time the QAPI team will ethe effectiveness of the intervendetermine if continued auditing inecessary. MDS nursing is responsible for implementing the acceptable placorrection.	made by the had a see of antify that are the continuous arrivation and the engarding ments for see of an arrivation and the total and coordinate evaluate tions to see the continuous and coordinate evaluate tions to see the continuous and coordinate evaluate tions to see the continuous arrivation and coordinate evaluate tions to see the continuous arrivation arr	ory  t  t  on  c	
	Resident #119 's mo	st recent quarterly MDS					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE : COMPI	LETED
		345115	B. WING _			10/	) 18/2019
	ROVIDER OR SUPPLIER	JRY		STREET ADDRESS, CITY, STATE, ZIP CO 635 STATESVILLE BOULEVARD SALISBURY, NC 28144	DE		
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F 641	MDS assessment revitwo or more falls sindingury (not major). Not injury were reported to prior assessment.  An interview was con AM with MDS Nurse reviewed Section Joy MDS dated 9/28/19 a resident experienced major). When asked radius would be constall, the MDS nurse symodification would necorrect this MDS assessments was con PM with the facility so During the interview, Resident #119 was do DON stated she would assessments to be accompany to the property of	ed 9/28/19. Section J of the realed Resident #119 had e the prior assessment with of falls resulting in a major to have occurred since the ducted on 10/17/19 at 10:55 #1. Upon request, the nurse of Resident #119 's quarterly and confirmed it reported the 2+ falls with injury (not if fractures of the ulna and idered a major injury from a stated, "Yes." She reported a seed to be submitted to essment.  ducted on 10/17/19 at 3:50 to Director of Nursing (DON). the MDS coding error for iscussed. When asked, the	F	341			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345115	B. WING			C <b>10/18/2019</b>
	ROVIDER OR SUPPLIER  US HEALTH AT SALISBU			STREET ADDRESS, CITY, STATE, ZIP COD 635 STATESVILLE BOULEVARD SALISBURY, NC 28144	)E	10/10/2019
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F 641	Continued From page	e 6	F 6	41		
	section N0450 of the	eceived by the resident				
	Medication Administrative revealed she received as scheduled on each MDS look back period quetiapine to be given three times daily; 25 to 0.5 tablets by mouth of the control of the contr	d the following medications of the 7 days during the d: 50 milligrams (mg) of as one tablet by mouth of quetiapine to be given as every evening at bedtime; one to be given as one tablet				
	AM with MDS Nurse is reviewed Section N or MDS dated 9/28/19. resident 's September the resident did received in medication on 7 out of back period. When a response for N0450 vonurse reported it should be sectioned in the section of the section o	ducted on 10/17/19 at 10:55 #1. Upon request, the nurse f Resident #119 's quarterly She also reviewed the er 2019 MAR and confirmed we an antipsychotic of 7 days during the look sked what the correct yould have been, the MDS alld have indicated Resident yochotic medication(s) on a				
F 656 SS=D	PM with the facility 's During the interview, Resident #119 was di DON stated she woul assessments to be ad Develop/Implement C	ducted on 10/17/19 at 3:50 Director of Nursing (DON). the MDS coding error for scussed. When asked, the dexpect the MDS courate in submissions.	F 6	556		11/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345115	B. WING		C 10/18/2019
	ROVIDER OR SUPPLIER  US HEALTH AT SALISB	URY		STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144	10/10/2013
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F 656	implement a comprecare plan for each reresident rights set for §483.10(c)(3), that in objectives and timefr medical, nursing, and needs that are identificated assessment. The condescribe the following (i) The services that or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, inclustreatment under §483 (iii) Any specialized sere a result of recommendations. If findings of the PASA rationale in the reside (iv) In consultation wire resident's represental (A) The resident's profuture discharge. Fact whether the resident' community was asselocal contact agencie entities, for this purpo (C) Discharge plans	ensive Care Plans cility must develop and hensive person-centered sident, consistent with the rth at §483.10(c)(2) and reludes measurable ames to meet a resident's d mental and psychosocial fied in the comprehensive mprehensive care plan must g - are to be furnished to attain ent's highest practicable d psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). services or specialized is the nursing facility will f PASARR a facility disagrees with the RR, it must indicate its ent's medical record. th the resident and the ative(s)- hals for admission and eference and potential for cilities must document is desire to return to the lessed and any referrals to less and/or other appropriate	F 65	6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345115	B. WING		10/1	) 18/2019
	ROVIDER OR SUPPLIER	LDV.		STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD	1 107	10/2013
ACCORDI	US HEALTH AT SALISBU	JRY		SALISBURY, NC 28144		
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F 656	section. This REQUIREMENT by: Based on record revifacility failed to develor addressed pain mana comprehensive Minimassessment. This oc (Resident #327) revies The findings included Resident #327 was a 2/28/19 with re-entry His cumulative diagnosyndrome. The reside absence from the factorium.  A review of Resident Data Set (MDS) asservealed the resident daily decision making only for his Activities of the exception of being He was reported to wonly 1-2 times during Section J of the asservesident received methods is for frequent pai was indicative of no prost severe pain). Sassessment reported	in paragraph (c) of this  is not met as evidenced  ew and staff interviews, the op a care plan which agement as triggered by his num Data Set (MDS) curred for 1 of 3 residents ewed for pain.  idmitted to the facility on from a hospital on 5/23/19. Sess included chronic pain ent left on a leave of fility on 7/1/19 and did not  #327 's admission Minimum ssment dated 3/7/19 had intact cognitive skills for . He required supervision of Daily Living (ADLs), with g independent with transfers. alk in his room or corridor the 7-day look back period. ssment revealed the dications on an "as needed" in rated as a 6 out of 10 (0 tain and 10 indicative of the	F 656	·	s gers pain tion care will add ator	
	A review of the reside					

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3	ODATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER  US HEALTH AT SALISB	l		STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144	l	10/18/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	Assessment Referent revealed the care are his admission MDS at the problem or condithad chronic complair received pain medicated Resident #327 's care Areview of Resident quarterly MDS assessalso conducted. See the resident received needed" basis for fre of 10. Section N repeto receive an opioid pays during the look. A review of Resident care plan (last revise The care plan did not An interview was con AM with MDS Nurse nurse reviewed Resident worksheets from the confirmed the care at triggered for review. Indicated the resident a focus area related Nurse #2 also review and medication histor Resident #327 received pain reliever used to should have been can Nurse #2 confirmed if planned for pain during the pain and pain the pain during the pain and pain pai	ce Date (ARD) of 3/7/19 ca for Pain was triggered by essessment. The nature of tion indicated the resident ats of pain with his knees and ations as needed. The CAA pain would be addressed in the plan.  #327 's most recent sment dated 5/23/19 was tion J of the MDS revealed medications on an "as quent pain rated as a 7 out orted the resident continued to back period.  #327 's comprehensive d 6/3/19) was conducted. de address pain management.  #327 's comprehensive d 6/3/19) to conducted. de address pain management.  #327 's CAA	F 65	56		

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG		(X3) DATE COMP	SURVEY LETED
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		345115	B. WING			10/	18/2019
	ROVIDER OR SUPPLIER  JS HEALTH AT SALISB	URY		STREET ADDRESS, CITY, STATE, ZIP COI 635 STATESVILLE BOULEVARD SALISBURY, NC 28144	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 656	During the interview, care plan information discussed. When ask would have expected to have been comple	s Director of Nursing (DON). the CAA Worksheets and for Resident #327 was ked, the DON reported she d a care plan related to pain sted for this resident.		656			
F 732 SS=C	must post the following basis:  (i) Facility name.  (ii) The current date.  (iii) The total number by the following categorian under the period of the following categorian to the following categorian to the following categorian care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census.  §483.35(g)(2) Posting (i) The facility must pospecified in paragrapidally basis at the beguin Data must be post (A) Clear and readable (B) In a prominent place residents and visitors.  §483.35(g)(3) Public staffing data. The fawritten request, maker	affing Information. equirements. The facility ing information on a daily  and the actual hours worked gories of licensed and taff directly responsible for ft: ss. al nurses or licensed s defined under State law). des.  g requirements. ost the nurse staffing data sh (g)(1) of this section on a ginning of each shift. ted as follows: ole format. acce readily accessible to ss. access to posted nurse cility must, upon oral or	F	732			11/15/19

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		COMPLETED
		345115	B. WING			
	ROVIDER OR SUPPLIER	BURY		STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144	being used has lew form has  Ing coordinator coordinator on of the new m will include hift. The instructed on form and what be included. If on the staffing sheet by nursing and the lator. It is shew staffing sheet by nursing and the lator. It is shew staffing sheet by nursing and the lator. It is shew staffing sheet by nursing and the lator. It is shew staffing sheet by nursing and the lator. It is shew staffing sheet by nursing and the lator. It is shew shall be lator. It is shew shall be lator. It is shown that she lator. It i	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION
F 732	exceed the commure §483.35(g)(4) Facility requirements. The posted daily nurse is 18 months, or as registered. This REQUIREMEN by: Based on review of forms, nursing schefacility failed to accuprovided by licenser for 9 out of 9 daily previewed.  Findings included:  1. Review of the forms and daily nurse 37/2019, 8/8/2019, 9/28/2019, 10/1/2017 revealed the daily nurse accurate on the followa. The nursing scle 2:00 PM) for 8/6/207 Registered Nurse (F(NA) and 4 Medication scheduled to work 1 nurse staffing form 1 had provided 16 hor 72 hours of care and daily posted nurse is schedule for 2nd should no RNs and 4 daily posted nurse is 8/6/2019 indicated to service in the schedule of	ity standard.  Ty data retention facility must maintain the taffing data for a minimum of quired by State law, whichever  T is not met as evidenced the daily nurse staffing dules and staff interviews, the rately report care hours d and unlicensed personnel osted nurse staffing forms  Facility's daily nursing staffing sing schedules for 8/6/2019, 9/26/2019, 9/27/2019, 9, 10/2/2019, and 10/3/2019 ursing staffing forms were not	F 73	POC for F 732 Staffing The staffing form that was being usen discontinued and a new form been initiated. The DON trained the staffing coor and the staff development coordin 10/18/19 on the utilization of their staffing form. The new form will in the number of CMAs per shift. The Staffing Coordinator was instructed how to complete the new form and licensed personnel should be included All nurses will be educated on the requirements of the daily staffing 11/15/19 by the director of nursing staff development coordinator. DON or designee will review staff sheets daily till 100% achieved for consecutive days; than reviews we done 2 random days a week for 4 till 100% accuracy achieved; then times 3. The DON will findings to QAPI and will be reviewed and disin monthly QAPI meetings. The DON and/or staffing coordinate responsible for implementing the acceptable plan of correction.	rdinator nator on new nclude ne ed on d what luded. es sheet by g and the ring or 5 vill be weeks a monthly of the scussed ator will	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		OATE SURVEY COMPLETED
		345115	B. WING _			C 10/18/2019
	ROVIDER OR SUPPLIER  US HEALTH AT SALISB	URY		STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144	'	.67.13.23.10
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 732	(10:00 PM to 6:00 Al were scheduled to w staffing form reporter hours of care.  b. The nursing sch 8/7/2019 indicated 1 that date. The daily preported 14 NAs had and no MTs were on	ursing schedule for 3rd shift M) was reviewed and 10 NA rork. The daily posted nurse d 9 NA had provided 72  medule for 1st shift on 3 NAs and 4 MTs had worked roosted nurse staffing form d provided 112 hours of care the posted daily nurse	F 7	732		
	on 8/7/2019 was rev Practical Nurses (LP scheduled to work. T staffing form did not worked that shift, 3 L care, and 12 NA pro- nursing schedule for reported 11 NAs wer	ursing schedule for 2nd shift iewed and 1 RN 2 Licensed IN), 11 NAs and 4 MTs were The daily posted nurse indicate any RN or MT had LPNs provided 24 hours of wided 96 hours of care. The 3rd shift on 8/7/2019 re scheduled to work. The taffing form indicated 9 NAs irs of care.				
	was reviewed and 1 were scheduled to w posted nurse staffing 2 RNs had provided provided 104 hours on the daily posted r nursing schedule for reviewed and it repo scheduled to work. T staffing form did not that shift and 11 NAs care.	RNs, 14 NAs and 4 MTs ork 1st shift. The daily g form for 8/8/2019 indicated 16 hours of care, 13 NAs of care and no MT was noted nurse staffing form. The 2nd shift on 8/8/2019 was rted 12 NAs and 4 MTs were The daily posted nurse indicate any MT had worked is had provided 88 hours of				
		edule for 1st shift 9/26/2019 RNs, 3 LPNs and 4 MTs				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
					С
	345115	B. WING _		1/	0/18/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 635 STATESVILLE BOULEVARD	)E	
ACCORDIUS HEALTH AT SALIS	BURY		SALISBURY, NC 28144		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
posted nurse staffing 2 RNs had provided provided 32 hours noted on the daily nursing schedule for reviewed and it should be a scheduled to work. The daily posted that shift. The shift on that date rescheduled to work staffing form indicated of care.  e. The nursing so was reviewed and were scheduled to posted nurse staffing 3 LPNs provided 2 provided 97.5 hours noted on the daily nursing schedule for reviewed and it reviewed 32 hours 75 hours of care and The nursing sched reported 10 NAs with daily posted nurse had provided 67.5  f. The nursing so was reviewed and	work 1st shift. The daily ng form for 9/26/2019 indicated d 16 hours of care, 3 LPNs of care, and no MTs were posted nurse staffing form. The or 2nd shift on 9/26/2019 was owed no RNs were scheduled d 4 MTs were scheduled to sted nurse staffing form ovided 20 hours of care, 2 hours of care and no MT had the nursing schedule for 3rd eported 11 NAs were. The daily posted nurse sted 10 NAs provided 75 hours of care, 13 NAs work 1st shift. The daily ng form for 9/27/2019 indicated 4 hours of care, 13 NAs is of care and no MTs were posted nurse staffing form. The for 2nd shift on 9/27/2019 was realed 1 RN, 2 LPNs, 9 NAs scheduled to work. The daily ng form indicated 4 LPNs of care, 10 NAs provided d no MT had worked that shift. The staffing form indicated 9 NA	F	732		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345115	B. WING		C 10/18/2019
	ROVIDER OR SUPPLIER  US HEALTH AT SALIS	BURY		STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144	10.10.2010
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 732	1 RN provided 8 ho 75 hours of care an daily posted nurse s schedule for 2nd sh and it showed 4 MT The daily posted nu MTs had worked tha for 3rd shift reveale work on that date. T form indicated 10 N care.  g. The nursing sc was reviewed and 1 MTs were schedule posted nurse staffin 2 RNs provided 16 provided 32 hours of hours of care and n posted nurse staffin for 2nd shift on 10/1 showed no RNs we 10 NAs and 4 MTs of daily posted nurse s had provided 24 ho provided 16 hours of 90 hours of care an shift. The nursing so reviewed and 1 RN scheduled to work. staffing form for tha worked, 3 LPNs pro NA provided 60 hou  h. The nursing so was reviewed and 1 MTs were schedule posted nurse staffin	urs of care, 10 NAs provided d no MTs were noted on the staffing form. The nursing lift on 9/28/2019 was reviewed is were scheduled to work. It is staffing form indicated no at shift. The nursing schedule d 11 NAs were scheduled to the daily posted nurse staffing As had provided 75 hours of leading form for 10/1/2019 RN, 2 LPNs, 14 NAs and 4 d to work 1st shift. The daily g form for 10/1/2019 indicated hours of care, 4 LPNs of care, 11 NAs provided 75 on MTs were noted on the daily g form. The nursing schedule 1/2019 was reviewed and it re scheduled to work, 3 LPNs, were scheduled to work. The staffing form indicated 3 RNs urs of care, 2 LPNs had of care, 12 NAs had provided d no MT had worked that chedule for 3rd shift was 1,2 LPNs and 12 NAs were The daily posted nurse t shift indicated no RN ovided 24 hours of care, and 8	F 73:	2	

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		345115	B. WING			C <b>10/18/2019</b>
NAME OF PROVIDER OF				STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144		10/16/2019
	ACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
provided hours of posted in for 2nd s showed to work. indicated 10 NAs I MT had for 3rd s schedule staffing f provided ii. The was revi MTs wer posted in 2 RNs pi provided hours of posted in for 2nd s showed were schedule staffing f hours of care, 11 in o MT his schedule LPNs and daily postindicated hours of care.  The facil 10/17/20	care and nourse staffing thift on 10/2 1 RN, 12 N. The daily pure and provide worked that hift was revealed to work. Form for that 72 hours of the scheduled urse staffing thift on 10/3 1 RN, 2 LP and led to work orm indicate care, 3 LP NAS had provided 16 I RN, 2 LP and worked to the for 3rd shift on 10/3 1 RN, 2 LP and worked to the for 3rd shift on 10/3 1 RN, 2 LP and worked to the for 3rd shift on 10/3 1 RN, 2 LP and worked to the for 3rd shift on 10/3 1 RN, 2 LP and worked to the for 3rd shift on 10/3 1 RN, wo the for 3rd shift on 10/3 1 RN, wo the for 3rd shift on 10/3 1 RN, wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN wo the for 3rd shift on 10/3 1 RN shift o	f care, 11 NA provided 82.5 o MTs were noted on the daily g form. The nursing schedule /2019 was reviewed and it As and 4 MTs were scheduled osted nurse staffing form d provided 24 hours of care, d 105 hours of care and no e shift. The nursing schedule iewed, and 12 NAs were The daily posted nurse e shift indicated 9 NAs	F 7	32		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345115	B. WING		C <b>10/18/2019</b>
	ROVIDER OR SUPPLIER	JRY		STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D 4.T.E.
F 732 F 759 SS=D	aware she should not staffing totals. The so not aware the MTs sh posted nurse staffing reported the DON and helped to manage the as well as the 3rd shift the forms each morni. The Administrator wa at 4:47 PM and she redaily posted staffing for reflect the daily staffing Free of Medication Err CFR(s): 483.45(f)(1)  §483.45(f) Medication The facility must ensure \$483.45(f)(1) Medication percent or greater;	mes and stated she was not count the DON towards cheduler reported she was ould be listed on the daily form. The scheduler d the wound care nurse e daily posted staffing form, ft nurse, and she reviewed ng for accuracy.  Is interviewed on 10/17/2019 exported she expected the forms to be accurate and ng of the facility.  The ported of the facility of the facility of the facility.  The ported of the facility of the facility of the facility of the facility.  The ported of the facility of the	F 732		11/15/19
	record review, the fact medication error rate evidenced by 2 medic medication opportunit medication error rate (Resident #126) obserpass.  The findings included  1) Resident #126 was 10/9/19. Her cumulated	of less than 5% as cation errors out of 25 cies, resulting in a of 8% for 1 of 8 residents erved during medication		POC for F759 Medication Error Resident 126 had a complete review of medication orders and electronic Medication Administration Record. An audit of all residents on that unit wa conducted on 10/19/19 by the ADON and/or Director of Nursing for accuracy Medication Administration instructions. Employee 1 was educated on 10/15 by ADON for proper access to order instructions on eMAR/PCC. All nurses including current agency, were in-servi on accessing further instructions on	s of

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
		345115	B. WING			C 10/18/2019
	ROVIDER OR SUPPLIER	URY		STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144		10/10/2010
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 759	pain.  On 10/15/19 at 9:21 as she prepared and #126. The medication Lidoderm topical pate applied to the resider A review of the resider included the following (lidocaine). Apply to related to low back paskin daily. Remove a and remove per sche 9:00 AM).  An interview was con AM with Nurse #1. Difference #126 's electronic Markecord (eMAR) was the eMAR, the nurse order she looked at administration did no needed to be applied Upon further review of that only a portion of been visible during the discovered she need the word "more" (local eMAR) to enable her medication order. Wowas visible, the nurse instructions which incompatches needed to be shack. Nurse #1 repaware of the need to	AM, Nurse #1 was observed administered to Resident ins included one - 5% ch (a topical analgesic) int's lower back.  Lent's medication orders g: "Lidoderm Patch 5% skin topically in the morning ain. Place 2 patches onto and discard after 12 hours adule" (Start date 10/10/19 at discard after 12 hours adule" (Start date 10/10/19 at discard after 12 hours adule" (Start date 10/10/19 at discard after 12 hours adule to the interview, Resident edication Administration reviewed. Upon review of reported the portion of the luring the med pass to the resident's back. Of the eMAR, Nurse #1 found the medication order had be med pass. The nurse ed to click on or scroll over ated next to the order on the to view the entire hen the entire med order et was able to view dicated two Lidoderm et applied to Resident #126' ported she had not been expand her view of the MAR to ensure an entire	F 75	eMAR/PCC by 11/15/19. A medication observation of E was conducted on 10/19, 10/2 10/30, and 11/5 totaling 5 day Director of Nursing and achievaccuracy. A medication observation will conducted by the Unit Manage Employee 1 twice weekly for a maintain accuracy. A random med passes on 100 Hall and/will be conducted twice weekly weeks to ensure facility-wide a discussed in our monthly QAF DON is responsible for implem acceptable plan of correction.	22, 10/29, rs by the ved 100%  be er for 4 weeks to a audit of or 200 Hall y for 4 accuracy. and PI meetings. menting the	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	` ′	TE SURVEY MPLETED
		345115	B. WING			C 0/18/2019
	ROVIDER OR SUPPLIER	BURY		STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144	'	0/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 759	Continued From pag	ge 18	F 75	9		
	AM with Unit Manager reemand the Unit Manager reemand and reported the entire order whe She stated the phrase referred to scrolling looking at the eMAR medication order in it.  An interview was con PM with the facility During the interview errors and medication When asked what he DON stated, "They (should know how to follow that order."  2) Resident #126 was 10/9/19. Her cumula dementia with behave	er #1. During the interview, viewed Resident #126 's nursing staff needed to view n administering medications. Se, "hover to discover" over the word "more" when to enable the nurse to see a ts entirety.  Inducted on 10/16/19 at 4:05 s Director of Nursing (DON). The facility 's medication on error rate were discussed. For expectations were the nurses and medication aides) read the entire order and as admitted to the facility on ative diagnoses included vioral disturbance, disorder of us system, and low back				
	as she prepared and #126. The medication	AM, Nurse #1 was observed diadministered to Resident ons included one - 100 tof Vitamin B-1 administered				
	included the followin (thiamine) Give 100 for supplement. Giv	ent 's medication orders g: "Vitamin B-1 tablet mg by mouth one time a day e 2 tablets (200 mg) by tart date 10/10/19 at 9:00				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		TE SURVEY MPLETED
		345115	B. WING _			C <b>0/18/2019</b>
	ROVIDER OR SUPPLIER	SBURY		STREET ADDRESS, CITY, STATE, ZIP CO 635 STATESVILLE BOULEVARD SALISBURY, NC 28144	•	0/10/2013
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTI  CROSS-REFERENCED TO TI  DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 759	AM with Nurse #1 #126's electronic Record (eMAR) w the eMAR, the nur order she looked a administration did Vitamin B-1 (for a to be given to the of the eMAR, Nurs of the medication the med pass. Th to click on or scrol next to the order of view the entire me entire med order w to view instruction Vitamin B-1 (for a to be given to Res she had not been her view of the ins ensure an entire m An interview was of AM with Unit Manager eMAR and reporte the entire order w She stated the phi referred to scrollin looking at the eMA the medication ord An interview was of PM with the facility During the interview errors and medica When asked what	conducted on 10/15/19 at 9:55 . During the interview, Resident Medication Administration as reviewed. Upon review of rese reported the portion of the at during the med pass not indicate two tablets of total dose of 200 mg) needed resident. Upon further review se #1 found that only a portion order had been visible during e nurse discovered she needed I over the word "more" (located on the eMAR) to enable her to edication order. When the vas visible, the nurse was able s which indicated two tablets of total dose of 200 mg) needed dident #126. Nurse #1 reported aware of the need to expand effections on the eMAR to nedication order could be seen.  Conducted on 10/15/19 at 10:11 ager #1. During the interview, reviewed Resident #126 ' s and nursing staff needed to view nen administering medications. rase, "hover to discover" g over the word "more" when AR to enable the nurse to see	F 7	759		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER:  A. BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED		
		345115	B. WING			C 10/18/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 635 STATESVILLE BOULEVARD SALISBURY, NC 28144		10/10/2019
(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 (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 759	' '	e 20 read the entire order and	F 7	59		