PRINTED: 12/03/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  SURRY COMMUNITY HEALT AND REHAB CENTER  SURRY COMMUNITY HEALT AND REHAB CENTER  SURRY COMMUNITY HEALT AND REHAB CENTER  SUBJECT ADDRESS, CITY, STATE, ZIP CODE #24 ALRED MILL ROAD MOUNT ARRY, NC. 27930  PREDICE AND GRAPH DEPICIENCY HUST BE PRECEDED BY FULL TAG.  IN PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPRETED AND FOR PROVIDERS PLAN OF CORRECTION SHOULD BE COMPRETED AND FOR PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPRETED AND FOR PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPRETED AND PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPRETED AND PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPRETED AND PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPRETED AND PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPRETED AND PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPRETED AND PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPRETED AND PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPRETED AND PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPRETED AND PROVIDERS PLAN OF CORRECTION PROVIDERS P	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED: `		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
SURRY COMMUNITY HEALTH AND REHAB CENTER  SURMARY STATEMENT OF DEFICINCIES TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  E 000  Initial Comments  A recertification survey was conducted on 10/28/19 through 10/31/19 by the Division of Health Service Regulation, Nursing Home Section. The facility was in compliance with the requirements of CFR 433.73, Emergency Preparadness. Event 10 #89BH11.  F 695 SS=E  S=E  CFR(s): 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning. This REQUIREMENT is not met as evidenced by:  B ased on observations, record review, staff, and Physician interviews the facility failed to administer oxygen at the physician prescribed dose for 4 of 6 residents sampled for respiratory care (Resident #3-46).  The findings included:  The Recident #10 was readmitted to the facility on 01/30/19 with diagnoses that included: end stage renal disease, chronic obstructive pulmonary disease (COPD), acute pulmonary deem and others.  Review of a physician's order dated 01/30/19  F 695 Respiratory/Tracheostomy Care and			345191	B. WING		10/31/2019	
PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   CROSS REFERENCED TO THE APPROPRIATE   CROSS REFERENCED TO THE APPROPENT   CROSS R			O REHAB CENTER		542 ALLRED MILL ROAD		
A recertification survey was conducted on 10/28/19 through 10/31/19 by the Division of Health Service Regulation, Nursing Home Section. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID #98F111.  F 695 SS=E  \$ 483.25(i) Respiratory Care and Suctioning CFR(s): 483.25(i)  \$ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning, The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.  This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Physician interviews the facility failed to administer oxygen at the physician prescribed dose for 4 of 6 residents sampled for respiratory care (Resident #10, Resident #8, Resident #55 and Resident #346).  The findings included:  1. Resident #10 was readmitted to the facility on 01/30/19 with diagnoses that included: end stage renal disease, chronic obstructive pulmonary disease (COPD), acute pulmonary edema and others.  Review of a physician's order dated 01/30/19  F 695  F 6	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E COMPLETION	
Health Service Regulation, Nursing Home Section. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID #9BF11.  F 695 Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Physician interviews the facility failed to administer oxygen at the physician prescribed dose for 4 of 6 residents sampled for respiratory care (Resident #10, Resident #8, Resident #55 and Resident #346).  The findings included:  1. Resident #10 was readmitted to the facility on 01/30/19 with diagnoses that included: end stage renal disease, chronic obstructive pulmonary disease (COPD), acute pulmonary edema and others.  Review of a physician's order dated 01/30/19  Health sequences  F 695  Please accept this Plan of Correction(POC) as Surry Community Health and Rehabilitation Center's credible allegation of compliance. Preparation and execution of this POC does not constitute admission or agreement with the findings of non-compliance.  The POC is being provided in pursuit to federal and state requirements which require an acceptable plan of correction as a condition of continued certification. Date of alleged compliance is November 25, 2019.  F695 Respiratory/Tracheostomy Care and	E 000		ey was conducted on	E 000			
SS=E CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.  This REQUIREMENT is not met as evidenced by:  Based on observations, record review, staff, and Physician interviews the facility failed to administer oxygen at the physician prescribed dose for 4 of 6 residents sampled for respiratory care (Resident #10, Resident #8, Resident #55 and Resident #346).  The findings included:  1. Resident #10 was readmitted to the facility on 01/30/19 with diagnoses that included: end stage renal disease, chronic obstructive pulmonary disease (COPD), acute pulmonary edema and others.  Review of a physician's order dated 01/30/19  F695 Respiratory/Tracheostomy Care and		Health Service Regul Section. The facility requirements of CFR Preparedness. Even	ation, Nursing Home was in compliance with the 483.73, Emergency t ID #9BFI11.				
tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.  This REQUIREMENT is not met as evidenced by:  Based on observations, record review, staff, and Physician interviews the facility failed to administer oxygen at the physician prescribed dose for 4 of 6 residents sampled for respiratory care (Resident #10, Resident #8, Resident #55 and Resident #346).  The findings included:  The findings included:  1. Resident #10 was readmitted to the facility on 01/30/19 with diagnoses that included: end stage renal disease, chronic obstructive pulmonary disease (COPD), acute pulmonary edema and others.  Review of a physician's order dated 01/30/19  Tensulty finding tracheostomy care and tracheal such and responsible to the facility on 101/30/19 with diagnoses that included: end stage renal disease, chronic obstructive pulmonary disease (COPD), acute pulmonary edema and others.  Review of a physician's order dated 01/30/19  The findings included:  Review of a physician's order dated 01/30/19  The findings included:  Review of a physician's order dated 01/30/19  The findings included:  Review of a physician's order dated 01/30/19  The findings included:  Review of a physician's order dated 01/30/19  The findings included:  Review of a physician's order dated 01/30/19			stomy Care and Suctioning	F 69	5	11/25/19	
Physician interviews the facility failed to administer oxygen at the physician prescribed dose for 4 of 6 residents sampled for respiratory care (Resident #10, Resident #8, Resident #55 and Resident #346).  The findings included:  1. Resident #10 was readmitted to the facility on 01/30/19 with diagnoses that included: end stage renal disease, chronic obstructive pulmonary disease (COPD), acute pulmonary edema and others.  Preparation and execution of this POC does not constitute admission or agreement with the findings of non-compliance. The POC is being provided in pursuit to federal and state requirements which require an acceptable plan of correction as a condition of continued certification. Date of alleged compliance is November 25, 2019.  Preparation of compliance. The POC does not constitute admission or agreement with the findings of non-compliance. The POC is being provided in pursuit to federal and state requirements which require an acceptable plan of correction as a condition of continued certification. Date of alleged compliance is November 25, 2019.		tracheostomy care and The facility must ensure needs respiratory care care and tracheal succare, consistent with practice, the comprehate care plan, the resider and 483.65 of this sull This REQUIREMENT by:	nd tracheal suctioning. ure that a resident who e, including tracheostomy ctioning, is provided such professional standards of nensive person-centered hts' goals and preferences, bpart.  is not met as evidenced		Disease accept this Disease		
1. Resident #10 was readmitted to the facility on 01/30/19 with diagnoses that included: end stage renal disease, chronic obstructive pulmonary disease (COPD), acute pulmonary edema and others.  Review of a physician's order dated 01/30/19  federal and state requirements which require an acceptable plan of correction as a condition of continued certification. Date of alleged compliance is November 25, 2019.  F695 Respiratory/Tracheostomy Care and		Physician interviews administer oxygen at dose for 4 of 6 reside care (Resident #10, F and Resident #346).	the facility failed to the physician prescribed nts sampled for respiratory Resident #8, Resident #55		Correction(POC) as Surry Community Health and Rehabilitation Center's credible allegation of compliance. Preparation and execution of this POC does not constitute admission or agreement with the findings of non-compliance.		
		01/30/19 with diagnost renal disease, chronic disease (COPD), acutothers.	ses that included: end stage c obstructive pulmonary te pulmonary edema and		federal and state requirements which require an acceptable plan of correctio as a condition of continued certification Date of alleged compliance is Novemb 25, 2019.	n n. er	
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	10001	read, oxygen at 2-4 li	ters per nasal canula.		Suction		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

**Electronically Signed** 11/21/2019

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.

PRINTED: 12/03/2019 FORM APPROVED OMB NO. 0938-0391

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<b>345191</b> B. WING	10/31/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STA	-
SURRY COMMUNITY HEALTH AND REHAB CENTER  542 ALLRED MILL ROAD	
MOUNT AIRY, NC 27030	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE	PLAN OF CORRECTION (X5) TIVE ACTION SHOULD BE COMPLETION CED TO THE APPROPRIATE EFICIENCY)
moderately impaired for daily decision making and required extensive assistance with activities of daily living. The MDS further revealed that Resident #10 required the use of oxygen during the assessment reference period and no shortness of breath was identified.  Review of a care plan revised on 08/02/19 read, Resident #10 had oxygen therapy related to respiratory illness, COPD, pulmonary fibrosis, and respiratory care. The goal of the care plan read, Resident #10 will have no complications related to COPD. The interventions included: oxygen as ordered via nasal canula.  Review of Resident #10's oxygen saturation (amount of oxygen in the blood) from 10/01/19  Review of Resident #10's oxygen saturation (amount of oxygen in the blood) from 10/01/19  An observation of Resident #10 was made on 10/28/19 at 12:13 PM. He was resting in bed with eyes open. He was alert and verbal and indicated he had just returned from dialysis. He had oxygen in his nose via a nasal canula. The oxygen concentrator was sitting next to his bed and was set to deliver 5 liters of oxygen. No shortness of breath was noted.  at the physicians profe 6 residents. Resider and 346 were immeand adverse outcomes wooxygen and 346 were immeand 346	diately assessed for with none noted. stered per physicians  require the use of or this deficient as performed by the on 11/1/2019 of th orders for oxygen. The noted. For enoted, arding oxygen orders for physician order will arrow of Nursing, of Nursing, Unit Coordinators. This do into the orientation of the physician order will have a coordinated by hired licensed of the orientation of the

Facility ID: 953479

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		TE SURVEY MPLETED	
		345191	B. WING _		1	0/31/2019
	ROVIDER OR SUPPLIER  DMMUNITY HEALTH A	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION ( CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	Continued From pa	ge 2	F 6	95		
	10/29/19 at 1:50 PM bed with his eyes conose via a nasal ca was sitting next to h	Resident #10 was made on M. Resident #10 was resting in losed. He had oxygen in his mula. The oxygen concentrator his bed and was set to deliver No shortness of breath was				
	10/30/19 at 1:50 PM bed with his eyes o returned from dialys via a nasal canula. sitting next to his be	Resident #10 was made on M. Resident #10 was resting in pen and indicated he just sis. He had oxygen in his nose The oxygen concentrator was ed and was set to deliver 5 shortness of breath was				
	with Nurse #1 on 10 confirmed he was of Resident #10. He sprescribed 2-4 liters oxygen saturation a observed Resident and confirmed that oxygen. He added to oxygen level dropped him ready for dialyst to help him. He add had stabilized back oxygen back down amount of oxygen. temporarily turn the continued to require physician should be continued to say the adjust the oxygen of	oservation were conducted 0/30/19 at 3:52 PM. Nurse #1 caring for and was familiar with stated that Resident #10 was so of oxygen to maintain an above 92%. Nurse #1 #10's oxygen concentrator it was set to deliver 5 liters of that at times Resident #10's ed when the staff were getting sis and they probably turn it up the det that when Resident #10 out the staff should turn his to the physician prescribed Nurse #1 stated it was ok to expect up to 5 liters but if he et that much oxygen then the enotified for new orders. He at Resident #10 was unable to concentrator himself due to the hands. He added that he was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			10/31/2019	
	ROVIDER OR SUPPLIER  DMMUNITY HEALTH A	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 695	during his shift but I not aware that the of the physician preson.  An observation of F 10/30/19 at 4:12 PN bed with eyes open had oxygen in his moxygen concentrate and was set to delive shortness of breath.  An interview was concentrated and was set to delive shortness of breath.  An interview was concentrated and was set to delive shortness of breath.  An interview was concentrated that the nurse the oxygen flow rate confirmed that the Fibeen on the physician difference in the physician for act that she had witness short of breath and oxygen so he could should be returned the stabilized, or the An interview was concentrated and oxygen so he could should be returned the stabilized, or the An interview was concentrated of the Physician correct dose of oxygen some adjusting orders.  An interview was concentrated and the physician correct dose of oxygen some adjusting orders.	the oxygen concentrator had not yet done so and was concentrator was not set on ribed amount of oxygen.  Resident #10 was made on M. Resident #10 was resting in and was alert and verbal. He ose via a nasal canula. The or was sitting next to his bed ver 5 liters of oxygen. No was noted.  Inducted with the Unit 0/31/19 at 9:54 AM. The UM es were expected to check e at least once a shift. She Resident #10 should have an prescribed dose of oxygen nore then what was all expect the nurse to contact ditional orders. The UM stated sed Resident #10 become ask the staff to turn up his catch his breath but added it to what he was ordered when e physician notified.	F 6	95			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345191	B. WING			0/31/2019	
	PROVIDER OR SUPPLIER	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	DON stated that the monitor and check to shift. If the oxygen was prescribed, she would the flow rate to the oxygen was all care and the temporarily but once returned to the corresphysician should be.  An interview was considered and the temporarily but once returned to the corresphysician should be.  An interview was considered and the complex patient was all care and give the orders. He added the complex patient and orders for staff to accorder for staff t	Nurses were expected to he oxygen flow rate every was not on what was all expect the nurse to change correct dose. She added that gen level sometimes dropped staff would turn it up the stabilized it should be ested dose of oxygen or the notified.  Inducted with the Physician on M. The Physician stated that the staff some leniency with his staff some leniency with his staff some leniency with his staff some flexibility in his dijust it when they need too but the staff to follow the orders  I readmitted to the facility on loses that included: atory failure and others.  I an order dated 07/23/19 read, anula at 2 liters continuously.  I an revised on 07/23/19 read, doxygen therapy. The goal will have no signs or symptoms or protion through the review ons included: oxygen via	F 69				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
		345191	B. WING			10/31/2019
	ROVIDER OR SUPPLIER  DMMUNITY HEALTH A	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	and required total a daily living. The MD #8 required oxygen exertion and when the factor of the fac	#8's oxygen saturation in blood) from 10/01/19 evealed that the level was desident affect. Her head of bed she had oxygen in her nose There was an oxygen next to her bed and was set oxygen. No shortness of tesident #8 was made on made affect. Her head of bed she had oxygen in her nose there was an oxygen next to her bed and was set oxygen. No shortness of the she had oxygen in the strength oxygen in and had a flat affect. Her evated, and she had oxygen in a canula. There was an or sitting next to her bed and liters of oxygen. No shortness	F 69	95		
	10/29/19 at 1:52 PM bed with eyes open head of bed was ele her nose via a nasa oxygen concentrato was set to deliver 3 of breath was noted An observation of F	Resident #8 was made on  M. Resident #8 was resting in and had a flat affect. Her evated, and she had oxygen in al canula. There was an ar sitting next to her bed and liters of oxygen. No shortness al.  Resident #8 was made on  M. Resident #8 was resting in				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		345191	B. WING _			10/31/2019
	ROVIDER OR SUPPLIER	ID REHAB CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CO 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		
(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 C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 695	Continued From pag	ge 6	F 6	695		
	head of bed was ele her nose via a nasal oxygen concentrator was set to deliver 3 of breath was noted An observation of R 10/30/19 at 1:52 PM	esident #8 was made on . Resident #8 was resting in				
	head of bed was ele her nose via a nasal oxygen concentrator	and had a flat affect. Her vated, and she had oxygen in canula. There was an sitting next to her bed and liters of oxygen. No shortness				
	with Nurse #1 on 10 confirmed he was ca Resident #8. He star prescribed 2 liters of Resident #8's oxyge that it was set to del adjusted it back to 2 Resident #8 was unconcentrator becaus added that he was econcentrator during so and was not awa not on the physician and it should have be An interview was co Manager (UM) on 10	nducted with the Unit 0/31/19 at 9:54 AM. The UM				
	the oxygen flow rate confirmed that the R	es were expected to check at least once a shift and esident #8 should have been scribed dose of oxygen.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345191	B. WING		10/31/2019
	ROVIDER OR SUPPLIER  OMMUNITY HEALTH AN	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 695	Administrator stated follow the physician of correct dose of oxygon spoken to the Physician and spoken adjustment of the spoken and spok	aducted with the B1/19 at 10:06 AM. The that she expected the staff to orders and administer the en. She added that she had ian and he was going to ents to Resident #8's orders.  Iducted with the Director of 1/31/19 at 10:06 AM. The Nurses were expected to e oxygen flow rate every as not on what was dexpect the nurse to change orrect dose.  Iducted with the Physician on 1/4. The Physician stated that e some adjustments to and give the staff some ers. He added that he follow the orders provided.  Is admitted to the facility on ted on 09/16/19 with led chronic obstructive COPD), sleep apnea and ated 09/16/19 specified have her oxygen saturations is of continuous oxygen rula.	F 698	5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		345191	B. WING		1	0/31/2019
	ROVIDER OR SUPPLIER	ID REHAB CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE  542 ALLRED MILL ROAD  MOUNT AIRY, NC 27030		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 695	use of oxygen for CC nasal cannula was to According to the mersaturations were mo and documented on Administration Recoon 10/28/19 at 10:4: in bed wearing a nasstated she felt bad a x-ray. Her oxygen c 3 liters of continuous On 10/29/19 at 9:55 wearing her nasal ca concentrator. The coliters.  On 10/30/19 at 3:08 wearing her nasal ca concentrator. The colorest concentrator.	and she received n.  d on 09/23/19 related to the DPD specified oxygen via a be used as indicated.  dical record, oxygen intored every shift by a nurse the Medication rd (MAR).  3 AM PM Resident #55 was sal cannula. The resident ind was waiting on a chest oncentrator was on and set at	F 69			
	every shift and been Nurse #2 was asked settings and adjusted liters because the co She reported she was setting and had not of day. She also report capable of adjusting	en saturations were checked running 94-96% (normal). I about the concentrator d the oxygen settings to 2 oncentrator was set to 3 liters. As unaware of the wrong checked the concentrator that ted the resident was not the machine and she had no or how the settings had been				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			0/31/2019	
	ROVIDER OR SUPPLIER	AND REHAB CENTER	1	STREET ADDRESS, CITY, STATE, ZIP ( 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 695	interviewed and exponsive monitoring include saturation and che settings. She addidust oxygen sett. The Unit Manager oxygen concentration the room to make stated nurses assishould check the devery shift.  On 10/31/19 at 10 (DON) was interviewed flow rate for reside flow rate was recemedical record. So response for monitor the DON explained expected to docume concentrator setting reviewed Resident concentrator setting the nurses had be every shift according 4. Resident #346 10/09/19 with diagon respiratory failure and Aphysician's order monitor oxygen saturation and concentrator setting shift.	20 AM the Unit Manager was explained that residents requiring tored every shift. She specified d checking a resident's oxygen exking the concentrator ed that families would often ings without notifying the nurse. explained she would check an or setting every time she went are sure it was correct. She gned to residents with oxygen concentrator settings at least explained the pring oxygen saturations and ents was that an order for the fived and entered into the explained the flow rate every shift. The did that nurses were also then that they monitored the gray on the MAR. The DON at #55's MAR that specified the gray had been checked every as unable offer an explanation is oxygen settings were wrong if en checking the concentrator and to the MAR.	F	695			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		ATE SURVEY OMPLETED
		345191	B. WING _			10/31/2019
	ROVIDER OR SUPPLIER	ND REHAB CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 695	Continued From pa	ge 10	F 6	95		
	10/16/19 specified t	mum Data Set (MDS) dated he resident's cognition was ved supplemental oxygen.				
	use of oxygen for C	od on 10/16/19 related to the OPD (chronic obstructive specified oxygen via a nasal used as indicated.				
	saturations were mo	edical record, oxygen onitored every shift and Medication Administration				
	Resident #346 revenasal cannula and I set to 2.5 liters. Re	3 PM observations made of aled she was in bed wearing a ner oxygen concentrator was sident #346 had her eyes respond when her name was wed.				
	observations made she was in bed wea	00 AN and 12:53 PM of Resident #346 revealed uring a nasal cannula and her ur was set to 2.5 liters.				
		3 AM Resident #346 was in sal cannula and the oxygen 2.5 liters.				
	room to administer Nurse #2 used a pu Resident #346's ox	24 AM Nurse #2 entered the medications to Resident #346. Ilse oximeter to monitor ygen saturation. The reading #2 did not check the oxygen ngs.				
		AM the Unit Manager was plained that residents requiring				

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		E SURVEY MPLETED	
		345191	B. WING _		1	0/31/2019
	ROVIDER OR SUPPLIER  DMMUNITY HEALTH ANI	D REHAB CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	·	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 695	oxygen were monitor monitoring included of saturation and check settings. She added adjust oxygen setting. The Unit Manager ex oxygen concentrator in the room to make stated nurses assigns should check the concevery shift. The Unit Resident #346's wrong concentrator and representation.  On 10/31/19 at 10:35 (DON) was interviewed process for monitoring flow rate for residents flow rate was received medical record. She response for monitoring The DON explained to	ed every shift. She specified checking a resident's oxygen ing the concentrator that families would often s without notifying the nurse. plained she would check an setting every time she went sure it was correct. She ed to residents with oxygen centrator settings at least Manager was notified of an settings on her orted she would check the	F 6	95		