STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification Survey was conducted on 07/07/21 through 07/09/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# C0H611.	E 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		8/6/21

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

Electronically Signed | 07/24/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to, (a) provide a clean bedside commode that was causing a urine odor for 1 of 20 resident rooms (Room 217), (b) failed to repair holes exposing drywall in resident rooms for 2 of 20 resident rooms (Rooms 210 and 217) and, (c) failed to maintain walls at exit doors in good repair for 1 of 2 halls (North hall). The findings included: a. An observation on 7/8/21 at 9:36 AM revealed a bedside commode in Room 217 that was soiled with urine on the top of the lid, under the lid and the bucket. The commode lid had yellowish brown stains on it. The entire base of the bedside commode was covered with erosion. A strong urine odor was observed in the room. An observation on 7/9/21 at 11:53 AM revealed the urine odor remained in Room 217 and the bedside commode remained stained. On 7/9/21 at 12:03 PM, an interview was conducted with Housekeeper #1. She stated it was the nursing assistant ' s responsibility to clean the bedside commodes. She added the	F 584	Corrective action to be accomplished for the residents found to be affected by the deficient practice: The bedside commode in room 217 was replaced on 7/9/21. Nursing Assistant□s will continue to surface clean when emptying the bedside commode. Housekeeping will thoroughly clean the bedside commode on the same schedule as toilet cleaning. Additional bedside commodes and replacement buckets are in stock for replacement as needed. Room walls in room 210 behind A bed were repaired on 7/12/21. Room walls in room 217 behind A bed was repaired on 7/15/21. The wall beside the North Hall Exit door drywall repairs have been started and will be completed with baseboard replaced by 8/6/21. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 2 bedside commode in Room 217 was very old and some of the stains would not come off. Using a wet paper towel, Housekeeper #1 observed the surveyor remove some of the urine stains from the bedside commode. On 7/9/21 at 12:04 PM an interview was conducted with Nurse #1. She stated nursing assistants were responsible for cleaning the bedside commodes. She stated if they needed a new one, they went downstairs to get one, but they were hard to come by. On 7/9/21 at 1:11 PM, an interview was conducted with NA #1. She stated the empties the bedside commode for the resident in Room 217 and wipes it clean but, sometimes is unable to get it completely clean. b. An observation on 7/8/21 at 8:59 AM revealed two large holes exposing drywall behind the "A" bed in Room 210. An observation on 7/8/21 at 9:36 AM revealed two holes exposing drywall behind the "A" bed in Room 217. On 7/9/21 at 2:30 PM, Housekeeper #2 was interviewed. She stated the holes in the wall behind the bed in Room 210 were there for a little while and she recalled letting her supervisor know. She stated she wrote things down when she found things that needed to be repaired in the resident rooms. On 7/9/21 at 1:18 PM, an interview was conducted with the Maintenance Director. He stated he has submitted 4 different options to the Quality Assessment and Performance Improvement Committee regarding renovating	F 584	The Housekeeping manager and Maintenance director met with Administrator on 7/15/21. It was clarified that repairs are continually worked and maintained versus renovations that are planned and budgeted. The Housekeeping manager and Maintenance director went together to each room and hallways to visually inspect and compile a list of holes or drywall to be repaired. After compiling the list on 7/15/21, engineering began systematically making repairs. Supplies were approved and ordered for repairs. An additional 14 rooms were identified for drywall repair. All repairs will be completed by 8/6/2021. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The Housekeeping manager and Maintenance director will make weekly rounds to inspect and create a worklist. This will be updated weekly in the subsequent rounds to ensure prior repairs have been completed and new repairs needed will be added. Housekeeping will continue to monitor walls with daily cleaning for needed repairs and complete work orders. Engineering will continue to make daily rounds and initiate repairs. Indicate how the facility will monitor our performance to make sure that solutions are sustained:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 rooms and correcting things like holes in the walls. He further stated it has been discussed frequently but budget concerns prevent action. The maintenance director observed the holes in Room 210 and stated he was unaware of the holes in the room. He added he and his assistant conduct daily room rounds. c. An observation on 7/9/21 at 2:27 PM revealed the wall near the North hall exit door had areas of exposed drywall where the baseboard was pulled away from the wall. There was areas of cracked drywall up the right and left sides of the wall beside the door.	F 584	The Housekeeping manager and Maintenance director will make weekly rounds for 3 months and then monthly for 1 year. The Housekeeping manager will monitor condition and cleanliness of bedside commode weekly for 3 month and then monthly for 1 year. Performance will be monitored and reported monthly to the Nursing Home QAPI meeting as well as the Housewide Quality Improvement Committee. This reporting will continue monthly for 1 year to make sure the solution is maintained. Dates when corrective action will be completed: August 6, 2021.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		7/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 4 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to follow care plan interventions for a resident at risk for pressure ulcers for 1 of 12 sampled residents (Resident #18). The findings included: Resident #18 was admitted to the facility on 6/2/20 with diagnoses of dementia, chronic kidney disease, atrial fibrillation and diabetes mellitus. An annual Minimum Data Set assessment dated 5/26/21 revealed Resident #18 had severely impaired cognition. Resident #18 required total	F 656	Corrective action to be accomplished for the residents found to be affected by the deficient practice: Resident 18 had new heel protectors applied on 7/9/21. It was determined that resident 18□s heel protectors had become soiled and sent to laundry. Staff had failed to get new heel protectors when they had been soiled and sent to laundry. Staff were educated to get another pair our of floor stock if all of a resident□s heel protectors are soiled to ensure the care plan is followed for interventions for a resident at risk for pressure ulcers.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 5 assistance of 2 people with bed mobility and transfers and was incontinent of bowel and bladder. He had a risk for pressure ulcers but had no current pressure ulcers and utilized a pressure relieving device to his bed. The Care Area Assessment indicated pressure ulcers would be care planned. The care plan, updated on 5/27/21, revealed a problem for pressure ulcer risk. An intervention included heel protectors while in bed. An assessment used to determine pressure ulcer risk dated 5/26/21 revealed Resident #18 was at high risk for developing pressure ulcers. A review of Resident #18 ' s physician ' s orders revealed an order for heel protectors while in bed. An observation on 7/8/21 at 9:36 AM revealed Resident #18 lying in bed with his heels directly on the mattress. There were not heel protectors on Resident #18. An observation on 7/9/21 at 11:53 AM revealed Resident #18 lying in bed with his heels directly on the mattress. There were not heel protectors on Resident #18. On 7/9/21 at 1:57 PM, an interview was conducted with NA #1. NA #1 was asked by the surveyor where Resident #18 ' s heel protectors were. NA #1 was observed looking around Resident #18 ' s room and inside his drawers and closet. NA #1 was unable to locate Resident #18 ' s heel protectors. She stated she did not know where they were, and they may have gone to the laundry and not returned to Resident #18 ' s	F 656	Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit for all other residents with care plan interventions for a resident at risk for pressure ulcers was completed on 7/16/21. Three other residents were care planned for interventions of heel protectors and found to have the heel protectors in place. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The DON or designee will monitor for care planned interventions weekly for 3 months and then monthly for one year. Education to all staff that if all heel protectors are soiled, new heel protectors will be pulled from floor stock and placed on resident. Education began on 7/16/21 and will be completed by 7/30/21. Indicate how the facility will monitor our performance to make sure that solutions are sustained: Performance will be monitored weekly for 3 months and monthly for 1 year and reported monthly to the Nursing Home QAPI meeting as well as the Housewide Quality Improvement Committee. This reporting will continue monthly for 1 year to make sure the solution is maintained. Dates when corrective action will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 6 room.	F 656	completed: 7/30/21	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		7/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 7 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain an accurate medical record in the area of medications for 1 of 5 residents (Resident #32) reviewed for unnecessary medications. The findings included:	F 842	Corrective action to be accomplished for the residents found to be affected by the deficient practice: The medical record for Resident #32 was reviewed and updated to reconcile medication orders and progress notes on 7/15/21. In addition, a review and update	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 8 Resident #32 was admitted to the facility on 7/29/19 with diagnoses of failure to thrive, dementia, hypertension, diabetes mellitus, osteoarthritis and polyneuropathy. A review of Resident #32 ' s physician ' s orders for May 2021 revealed Resident #32 was receiving the following medications: Norvasc 5 milligrams daily, enteric coated aspirin 81 milligrams daily, celexa 10 milligrams daily, Plavix 75 milligrams daily for 3 months, colace 100 milligrams daily, ferrous sulfate 325 milligrams daily, losartan 100 milligrams daily, metformin 500 milligrams every morning, myretriq 50 milligrams daily, naproxen 250 milligrams daily, Prilosec 20 milligrams daily, vitamin b-12 1,000 micrograms daily, vitamin d2 50,000 units weekly, Tylenol 1,000 milligrams three times a day, Aricept 10 milligrams at bedtime, melatonin 3 milligrams at bedtime, metformin 1,000 milligrams each evening, temazepam 15 milligrams at bedtime, loperamide 2 milligrams as needed, ultram 50 milligrams every 6 hours as needed. A monthly physician ' s progress note dated 5/26/21 revealed Resident #32 ' s current medications were listed as follows: Aricept 10 milligrams at bedtime, myrbetriq 50 milligrams daily, Wellbutrin SR 150 milligrams every 12 hours, tylenol 500 milligrams every 6 hours as needed, melatonin 5 milligrams at bedtime, aspirin enteric coated 81 milligrams daily, colace 100 milligrams daily, zantac 300 milligrams twice a day, carafate 1 gram three times a day before meals, vitamin b-12 1,000 milligrams daily, Xanax 0.25 milligrams daily as needed, metformin 500 milligrams at noon and supper, cozaar 100 milligrams daily, Lipitor 80 milligrams half tablet	F 842	was completed to reconcile that a diagnosis was present for each medication. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A medical record review was completed for the remaining 36 residents to reconcile physician orders with progress notes. Five additional records of the 36 were updated to reconcile medication orders and progress notes. In addition, a review and update was completed to reconcile a diagnosis was present for each medication. These reviews and updates were completed from 7/15/21 through 7/20/21. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: Providers will reconcile medication orders with progress notes monthly. Monthly orders will be reviewed for changes to reconcile they have been updated in the progress note by the nurse designated to check monthly orders. Indicate how the facility will monitor our performance to make sure that solutions are sustained: Medication orders will be reconciled with progress notes monthly for 1 year. Monthly orders will be reviewed for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 9 every other day, Fosamax 70 milligrams weekly, Norvasc 5 milligrams daily, tramadol 50 milligrams as needed, vitamin d 3 1.25 milligrams weekly, ambien 5 milligrams at bedtime as needed, Plavix 75 milligrams daily, nicotine 14milligrams/24 hour patch every 24 hours, albuterol sulfate 108 micrograms aerosol powder 2 puffs as needed, Zofran 8 milligrams twice a day as needed. An acute physician ' s progress note dated 6/16/21 revealed no changes in the listed medications Resident #32 currently received. On 7/9/21 at 10:44 AM, Nurse #2, who made rounds with the physician, was interviewed. She stated when the physician made monthly resident visits, they went through the chart and updated the resident ' s medications and made other necessary changes. She did not know why Resident #32 ' s medications were not updated.	F 842	changes to reconcile they have been updated in the progress note by the nurse designated to check monthly orders. This will be compiled and reported monthly. Performance will be monitored and reported monthly to the Nursing Home QAPI meeting as well as the Housewide Quality Improvement Committee. This reporting will continue monthly for 1 year to make sure the solution is maintained. Dates when corrective action will be completed: 7/20/21	