STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 and complaint investigation was conducted on 11/04/24 through 11/08/24. Additional information was gathered through 11/20/24, therefore the exit date was changed to 11/20/24. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness Event ID #7KBR11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 11/04/24 through 11/08/204. Additional information was gathered through 11/20/24. Therefore, the exit date was changed to 11/20/24. Event ID# 7KBR11. The following intakes were investigated: NC00215217, NC00220692, NC00222454, and NC00224356. 2 of the 6 allegations resulted in a deficiency. Past non compliance and substandard quality of care identified at: CFR 483.25 at F689 at scope and severity of J. Immediate Jeopardy was identified at: CFR 483.35 at F726 at scope and severity of J. Immediate Jeopardy began on 09/21/24 and was removed on 11/19/24. A extended survey was conducted.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but	F 561		11/20/24

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

Electronically Signed | 12/12/2024

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F 561	Continued From page 1 not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and family interviews, the facility failed to honor a resident's choice to have a communal dining experience for 1 of 1 resident reviewed for choices (Resident #87). This had the potential to affect all residents who wish to have a communal dining experience. The findings included: Resident #87 was admitted to the facility on 08/25/21.	F 561	Communal dining was resumed 11/14/2024 Interviewed all residents by CNAs on halls on 11/14/2024 and all residents have the potential to be affected. On 11/14/2024, Communal Dining was resumed. Communal Dining will continue to be offered unless there are concerns for health/safety of residents such as an outbreak of a highly contagious virus. All residents will be interviewed prior to meals by NAs on hall to determine if resident wants to partake in communal dining.	

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F 561	Continued From page 2 A review of Resident #87's quarterly Minimum Data Set assessment dated 08/07/24 revealed Resident #87 to be severely cognitively impaired. She was coded as requiring supervision with eating. A review of Resident #87's annual Minimum Data Set assessment dated 12/07/23 revealed it was "very important" to Resident #87 to do things with groups of people. An interview with Resident #87's Family Member on 11/04/24 at 12:20 PM, revealed approximately 3 months ago the facility abruptly stopped communal dining in the dining room. Resident #87's Family Member stated Resident #87 enjoyed eating and the main dining room with other residents and felt the resident would prefer to do so. She also reported that she felt when Resident #87 ate in the dining room with other residents, her meal intakes were better. Resident #87's Family Member stated she visited with Resident #87 multiple times per week and was in the facility around meal times. An observation of the lunch meal service on 11/04/24 at 12:26 PM revealed no meals were served in the main dining room. An observation of the lunch meal service on 11/05/24 at 1:13 PM revealed no meals were served in the main dining room. An observation of the lunch meal service on 11/07/24 at 11:45 AM revealed no meals were served in the main dining room. During an interview with the Registered Dietician on 11/07/24 at 9:45 AM, he reported he was	F 561	Newly hired NAs will be educated on asking residents about communal dining during on-hire orientation. Beginning week of 12/9/2024, 10% of residents will be interviewed by administrator, or designee, weekly x4, monthly x4, to ensure given opportunity to attend communal dining. Results to be reported to QA for modifications.	

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F 561	Continued From page 3	F 561		

aware of multiple residents who preferred to eat in the dining room, but that the facility had not offered that "in some time". He stated he was unsure why the residents were not being offered communal dining and that it had stopped when the facility had a COVID-19 outbreak that was contained to staff members about 3 months ago and the facility had not offered it since. He stated he hoped the facility would begin offering communal dining soon as he felt the intakes of some residents, especially those on the restorative therapy caseload, were better when they ate in the main dining room with other residents.

During an interview with the Dietary Manager on 11/07/24 at 11:33 AM revealed communal dining had stopped about 2 ½ months ago. She stated she was unsure why it had stopped and that she had enough staff to provide a communal dining service in the main dining room. She also stated it was not a decision she made and that it would have been a decision made by the Director of Nursing or the Administrator. The Dietary Manager also stated she felt residents looked forward to communal dining and had better meal intakes when they dined in a group setting.

An interview with the Director of Nursing on 11/07/24 at 3:39 PM revealed communal dining was stopped when the facility had a COVID outbreak in mid-August and indicated it resolved around the 19th of September. She stated once the facility got through the outbreak and were planning on resuming communal dining, the area dealt with the aftermath of a hurricane that hit the area on 09/26/24 where roads were impassable, and the facility was working under their emergency preparedness plan. She stated the

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F 561	Continued From page 4 facility planned to resume communal dining on 11/04/24 but that the state survey agency had come into the facility, so it was not restarted. She indicated she hoped that communal dining would resume on 11/08/24. An interview with the Administrator on 11/07/24 at 5:00 PM revealed the facility was offering communal dining until there was a COVID outbreak amongst the staff that lasted approximately a month. He stated once the COVID outbreak was over, the area was hit by a hurricane on 09/26/24 which resulted in the facility being without power and many of the area roads being unpassable, preventing employees from being able to get to the facility. The Administrator reported that the facility was going to begin communal dining on 11/04/24 but was postponed due to the arrival of the state agency. He stated he expected communal dining to begin again, in full, on 11/11/24.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written	F 565		11/26/24

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F 565	Continued From page 5 requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to communicate the facility's efforts to address concerns voiced by residents during Resident Council meetings for 5 of 8 months reviewed (January 2024, February 2024, May 2024, June 2024, July 2024, August 2024, September 2024, and October 2024). Findings included: Review of the Resident Council Minutes for the period 01/30/24 through 10/29/24 revealed the following: a. The Resident Council meeting minutes dated 01/30/24 noted a concern was voiced that menus were not being provided for them to choose their meals for the following day. It was noted that the	F 565	Administrator attended meeting on 11/26/2024 and provided feedback to attendees about concerns raised at previous meeting 10/29/2024. The Council acknowledged understanding and that items were resolved. The social worker and administrator met and determined all residents attending resident council meetings have potential to be affected. On 11/13/2024, in-servicing was completed by VP of Operations to Activities staff, Social Worker, and Administrator on reporting of concerns from resident council to administrator and process of following up on those concerns. Any new activities staff and/or	

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F 565	Continued From page 6 Director of Nursing (DON) was made aware of the issues and stated that she had scheduled a meeting with Dietary to discuss the issues. b. The Resident Council meeting minutes dated 02/27/24 revealed the last meeting's minutes were reviewed and residents stated that everything was documented correctly. There was no indication that the facility's efforts (response, action and/or rationale) to address the concern(s) voiced during the 01/30/24 meeting was communicated to the Resident Council. c. The Resident Council meeting minutes dated 05/28/24 noted under the section, Grievances and Concerns, that residents voiced they were being asked about the next day's menu but were not always getting what they requested. It was noted that the Dietary Manager was in attendance who explained that sometimes residents didn't receive food items requested because of personal dietary restrictions and she would speak with staff to be more aware of choices offered. d. The Resident Council meeting minutes dated 06/25/24 revealed the last meeting's minutes were reviewed and residents stated that everything was documented correctly. Under the section, Grievances and Concerns, it was noted that residents voiced they were being asked about menus but were still not always getting what they requested and Social Worker (SW) #1 would address the issue. e. The Resident Council meeting minutes dated 07/30/24 revealed the last meeting's minutes were reviewed and residents stated that everything was documented correctly. There was no indication that the facility's efforts to address	F 565	administrator will be instructed on resident council response during on-hire orientation. Concerns noted from resident council will be logged in council minutes by Activities, addressed by administrator or designee, and reported back by administrator or designee to resident council in a timely manner no later than the proceeding resident council. Beginning 11/26/2024, Concerns will be documented by Activities Director, or designee, and audited by Administrator monthly x4, quarterly x2 and reported to QA for review.	

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F 565	Continued From page 7	F 565		

the concern(s) voiced during the 06/25/24 meeting was communicated to the Resident Council. Under the section, Grievances and Concerns, it was noted that residents voiced they were being asked about menus but they were still not always getting what was requested and SW #1 would address the issue with the DON and Dietary Manager.

f. The Resident Council meeting minutes dated 08/27/24 revealed the last meeting's minutes were reviewed and residents stated that everything was documented correctly. There was no indication that the facility's efforts to address the concern(s) voiced during the 07/30/24 meeting was communicated to the Resident Council.

g. The Resident Council meeting minutes dated 09/24/24 revealed the last meeting's minutes were reviewed and residents stated that everything was documented correctly. Under the section, Grievances and Concerns, it was noted that residents voiced that dietary ran out of iced tea and they only received water as a replacement. Residents also voiced they were supposed to receive stir fry the previous evening but all they received were veggies with a piece of meat on the side that was tough, fatty and they could not chew it. It was noted that SW #1 would address the issue with Dietary.

h. The Resident Council meeting minutes dated 10/29/24 revealed the last meeting's minutes were reviewed and residents stated that everything was documented correctly. There was no indication that the facility's efforts to address the concern(s) voiced during the 09/24/24 meeting was communicated to the Resident

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F 565	Continued From page 8	F 565		

Council.

A Resident Council group interview was conducted on 11/05/24 at 2:15 PM with Resident #19, Resident #23, Resident #31, Resident #32, Resident #35, Resident #44, Resident #72, Resident #85, Resident #109, and Resident #118 in attendance. All residents agreed that they brought up the same concerns each month during the Resident Council meetings but never received any feedback or response from Administration. Resident #118 stated it made them feel like they were not being seen or heard and their opinions didn't matter. The residents all agreed with Resident #118 and stated they would like to know they were being heard by receiving feedback from administration on the efforts that had been made or attempted to address their concerns.

During an interview on 08/24/24 at 3:08 PM, the Activity Director (AD) explained concerns voiced by residents during the monthly meetings were documented on the Resident Council meeting minutes and the minutes were provided to the Administrator and Department Managers to review. She explained that at the next Resident Council meeting, she read the minutes from the previous meeting to the group, asked them if everything was ok and then documented if the residents agreed the minutes were recorded correctly. The AD stated she did not receive any resolution or response to report back to the Resident Council regarding the concerns voiced during the previous meeting(s) and assumed the staff member who investigated the concern had provided the residents notification of the resolution.

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F 565	Continued From page 9 During an interview on 11/07/24 at 1:39 PM, SW #1 stated she attended the Resident Council meetings each month with the AD and the minutes from the previous meeting was reviewed with the residents attending the meeting. She explained the residents were asked if they were still having the same issues but neither she nor the AD provided them with feedback as to what was attempted to address their concerns. SW #1 stated when the same concerns were brought up each month, they were documented in the minutes and provided to the appropriate Department Manager to address. During an interview on 11/07/24 at 4:24 PM, the Administrator revealed he was aware of the repeated concerns voiced during the Resident Council minutes. He explained when concerns were voiced during the meetings, he implemented certain steps to address the concern but would not hear anything back during the month and when he received the next month's meeting minutes he noticed the same concern was brought back up. The Administrator was unaware that residents had voiced they felt as if they were not seen or heard and their opinion did not matter. He stated that going forward he would work on a better process of communication such as having a Department Manager or himself attend the Resident Council meeting to discuss what was attempted to address the concerns or ensure that the AD was provided the information so that she could review with the Resident Council during the next meeting.	F 565		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		12/9/24

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F 658	Continued From page 10 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff, and pharmacy interviews, the facility failed to obtain additional instructions from the provider when semaglutide (used to control blood sugar for Type 2 diabetics) was not available for 1 of 2 residents reviewed for medical record accuracy (Resident #85). The findings included: Resident #85 was admitted to the facility on 6/7/2021with diagnoses which included diabetes. Review of a quarterly Minimum Data Set (MDS) dated 10/1/2024 revealed Resident #85 was cognitively intact. Review of an order dated 10/1/2024 revealed Resident #85 was ordered to be administered semaglutide (used to control blood sugar for Type 2 diabetics) 0.5 mg subcutaneously once a week, on Sundays. Review of the November 2024 Medication Administration Record (MAR) revealed semaglutide 0.5 mg was documented as administered on Sunday,11/3/2024 at 8:00 pm by Nurse #2. An interview was conducted on 11/6/2024 at 3:28 pm with Nurse #2. Nurse #2 stated she worked night shift (7:00 pm to 7:00 am) on 11/3/2024 and was assigned Resident #85. Nurse #2 stated she	F 658	Medication was obtained from pharmacy on 11/5/2024 and administered by the nurse. Administrator and DON met on 11/7/2024 and determined that all residents who receive medication have the potential to be affected. 100% in-servicing of nurses completed 12/6/2024, by SDC and DON, on notifying doctor when medication is not available for administration and requesting further instruction on what to do. 100% Med-aides were inserviced 12/9/2024 on if medication is not available for administration to notify nurse so that doctor could be notified. Nurses/med-aids unable to attend initial in-servicings were not allowed to return to work until in-servicing was completed. Newly hired nurses will be educated upon hire. Beginning week of 12/9/2024, 10% of MARs will be reviewed by DON, or designee, to review if any meds could not be administered, the reason why could not, and if doctor/MD was notified. Reviews of MARs will be weekly x4, monthly x3. Results will be discussed in QA.	

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F 658	Continued From page 11	F 658		

had documented that she had given Resident #85 semaglutide on 11/3/2024, however when she had gotten to Resident #85's bedside, she realized there was not an adequate amount of medication in the pen to give the correct dose. Nurse #2 stated she called the pharmacy on 11/3/2024 and was told it was not time for Resident #85's semaglutide to be refilled. Nurse #2 stated when a resident ran out of medication, she would alert the pharmacy and request a refill and let the Nurse Supervisor know so they could get additional orders from the provider. Nurse #2 stated she let the Nurse Supervisor know on 11/5/2024.

An interview was conducted on 11/5/2024 at 8:51 am with Resident #85. Resident #85 stated the facility had been out of her semaglutide since 10/27/2024. Resident #85 stated she was scheduled to receive semaglutide on 11/3/2024 but was told by Nurse #2 that she was out. Resident #85 stated Nurse #2 had called the pharmacy and was told it was too early to have the medication refilled.

An interview was conducted on 11/5/2024 at 2:44 pm with the Nurse Supervisor. The Nurse Supervisor stated she was approached by Resident #85 on 11/5/2024. The Nurse Supervisor stated Resident #85 told her she had not gotten her semaglutide on 11/3/2024. The Nurse Supervisor stated she immediately called Nurse #2. The Nurse Supervisor stated Nurse #2 had told her she had documented the medication as administered and when she arrived in Resident #85's room to administer the medication, she realized there was not an adequate amount to give the correct dose. The Nurse Supervisor stated Nurse #2 should have

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	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 658	Continued From page 12 called the provider to be obtain an order to hold the semaglutide and for additional instructions. An interview was conducted on 11/7/2024 at 4:01 pm with the Director of Nursing (DON). The DON stated Resident #85 had informed the Nurse Supervisor she had not received her semaglutide. The DON stated the Nurse Supervisor called Nurse #2 and was told there was not enough medication in the pen to give the appropriate dose. The DON stated Nurse #2 should have called the provider for an order to hold the medication and for additional instructions.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to adjust air mattress settings to accommodate residents' weight for 2 of 6 residents (Resident #68 and Resident #20) reviewed for pressure ulcers.	F 686	Air mattresses operate based on relative weight of resident. Updated weights were received for 2 residents identified to not have correct setting on air mattresses (#20 and #68) by restorative CNAs on 11-12-2024 and settings of air mattress	11/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

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F 686	Continued From page 13 The findings included: 1. Resident #68 was admitted to the facility on 9/14/2024. Review of an admission Minimum Data Set (MDS) dated 9/21/2024 revealed Resident #68 was cognitively impaired and had a pressure injury. Review of a care plan dated 9/26/2024 revealed Resident #68 had a pressure ulcer and was at risk for further alteration in skin integrity/pressure ulcers due to immobility, incontinence, diabetes, and contractures. Interventions included staff were to provide pressure-reducing surfaces on the bed and chair. Review of Resident #68's weight dated 9/15/2024 was 123.8 pounds. An observation was conducted on 11/4/2024 at 12:01 pm of Resident #68. Resident #68's pressure mattress was set to 240 pounds. An observation was conducted on 11/5/2024 at 11:54 am of Resident #68. Resident #68's pressure mattress was set to 240 pounds. An interview was conducted 11/6/2024 at 9:17 am with the Wound Care Physician Assistant (PA). The Wound Care PA stated she noticed Resident #68's air mattress setting was set on 240 pounds. The Wound Care PA stated 240 pounds was not an appropriate setting. The Wound Care PA stated the adjustment of the air mattress should be a community effort to ensure the settings were appropriate for Resident #68's weight.	F 686	adjusted to reflect that weight. All residents utilizing air mattresses have potential to be affected. The administrator obtained a list of all residents on air mattresses and their weights. The individuals responsible for monitoring and set-up of air mattresses, Restorative aides, Treatment nurse, and Maintenance, were trained by DON and Administrator on 11/14/2024 on how to adjust and set the air mattress. Any new applicable staff will be trained on protocol and procedure for air mattresses. Restorative aides will monitor weekly weights (if ordered) or monthly weights to determine if there are significant weight changes that necessitate a change in air mattress settings. Upon order for air mattress, resident weight must be obtained to adjust mattress to appropriate setting unless resident preference signifies further adjustment and will be care planned. Beginning week of 11/18/2024, DON or designees were given most recent weight of resident obtained by restorative CNAs. An audit, beginning week of 11/18/2024, of air mattress settings and ensuring setting matches weight will be completed by DON, or designee, weekly x4, bi-weekly x4, and monthly x1. Reports to be brought to QA for review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 686	Continued From page 14	F 686		

An interview and observation were conducted on 11/7/2024 at 9:52 am with Nurse #1 as she provided wound care for Resident #68. Resident #68 was observed to have a nickel size open wound on her coccyx area with a tan wound bed. Nurse #1 stated a pressure mattress should be set according to Resident #68's weight. Nurse #1 stated an air mattress setting of 240 pounds would be too firm and would not help with pressure relief.

An interview was conducted on 11/7/2024 at 1:09 pm with the Maintenance Director. The Maintenance Director stated when a resident needed an air mattress, he would receive a work order and put one on the resident's bed. The Maintenance Director stated he would ask the hall nurse what the resident's weight was and set the air mattress to that weight. The Maintenance Director stated the nurses would adjust after he initially set up the air mattress.

An interview was conducted on 11/7/2024 at 3:58 pm with the Director of Nursing (DON). The DON stated she was not familiar with the air mattress settings and agreed that 240 pounds would not be a correct air mattress setting for Resident #68. The DON stated she was not sure if anyone was responsible for ensuring the air mattress settings were correct and that there was not currently any process for monitoring air mattress settings.

An interview was conducted on 11/7/2024 at 4:23 pm with the Administrator. The Administrator stated the Maintenance Director was responsible for the initial setup of the air mattress and adjusting the settings.

2. Resident #20 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 686	Continued From page 15	F 686		

10/12/20.

The quarterly Minimum Data Set (MDS) dated 09/05/24 revealed Resident #20 was moderately impaired in cognition for daily decision making. The MDS noted Resident #20 weighed 90 pounds and was at risk for developing pressure ulcers. She had a pressure reducing device for her bed and no unhealed pressure ulcers.

An observation conducted on 11/04/24 at 11:22 AM of Resident #20's pressure reducing mattress control settings revealed the weight for the mattress setting was a dial and it was turned halfway between 160 and 240 pounds.

An observation conducted on 11/05/24 at 8:50 AM of Resident #20's pressure reducing mattress control settings revealed the weight for the mattress setting was a dial and it was turned halfway between 160 and 240 pounds.

An observation conducted on 11/06/24 at 8:58 AM of Resident #20's pressure reducing mattress control settings revealed the weight for the mattress setting was a dial that was turned below 80 pounds.

During an interview on 11/06/24 at 8:59 AM, Nurse #4 stated she did not adjust settings for pressure reducing mattresses and was not sure who was responsible for doing so. Nurse #4 confirmed she was assigned to provide Resident #20's care but she had not looked at or changed the settings for Resident 20's pressure reducing mattress.

During an interview on 11/06/2024 at 9:17 AM, the Wound Care Physician Assistant (PA)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 686	Continued From page 16 explained the appropriate settings for a pressure reducing mattress should be set at the resident's current weight. During an interview on 11/07/2024 at 1:09 PM, the Maintenance Director stated that when a resident needed a pressure reducing mattress, he received a work order and put one on the resident's bed. The Maintenance Director stated he asked the hall nurse what the resident's weight was and set the pressure reducing mattress to that weight. The Maintenance Director stated the nurses would adjust the settings after he initially set up the air mattress. During an interview on 11/07/2024 at 3:58 PM, the Director of Nursing (DON) stated she was not familiar with the pressure reducing mattress settings and agreed that adjusting the settings for Resident #20's pressure reducing mattress between 160 and 240 pounds would not be the correct setting based on her current weight. The DON stated she was not sure if anyone was responsible for ensuring the settings for pressure reducing mattresses were correct and that there was no current process for the monitoring of settings for pressure reducing mattresses. During an interview on 11/07/2024 at 4:23 PM, the Administrator stated the Maintenance Director was responsible for the initial setup of pressure reducing mattresses and adjusting the settings.	F 686		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

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F 689	Continued From page 17 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Nurse Practitioner, Funeral Home Representative and Hospitalist interviews the facility failed to provide care in a safe manner. On 9/21/2024 Nurse Aide (NA) #1 was performing incontinence care for Resident #195 who was resting on an air mattress raised to waist height and rolled Resident #195 on her side away from NA #1 who proceeded to walk around to the other side of the bed at which time the air mattress decompressed. Resident #195 rolled off the side of the bed to the floor and was wedged between the bed and the wall. Resident #195 was transferred to the hospital where she was diagnosed with a right femur fracture, right inferior and superior pubic rami (pelvic) fractures, questionable nondisplaced sacral alar (lower spine) fracture. Resident #195 was a poor surgical candidate and was admitted to the hospital for comfort care. Resident #195 died on 9/22/2024. The deficient practice affected 1 of 6 residents (Resident #195) reviewed for accidents. The findings included: Resident #195 was admitted to the facility on 5/3/2016 with diagnoses which included dementia, acute respiratory failure, chronic respiratory failure, history of pulmonary embolism (PE, blood clot) and quadriplegia. Review of a care plan dated 6/3/2024 revealed	F 689	Past noncompliance: no plan of correction required.	

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	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

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F 689	Continued From page 18	F 689		

Resident #195 had impaired mobility and required assistance with activities of daily living (ADL).

Review of a quarterly Minimum Data Set (MDS) dated 8/30/2024 revealed Resident #195 was severely cognitively impaired with no behaviors, wandering, or rejections of care. Resident #195 was dependent for toileting, bathing, and personal hygiene. Resident #195 was dependent for bed mobility.

Review of a nursing note dated 9/21/2024 at 10:41 pm authored by Nurse #3 revealed at 6:15 am on 9/21/2024, Nurse Aide (NA) #1 came to the nurse's station and stated Resident #195 was on the floor. Resident #195 was observed laying on her right side beside the bed. Resident #195 was yelling "help me please." Nurse #3 advised NAs (names unknown) to get the mechanical lift and pad while Nurse #3 moved Resident #195's bed. The lift pad and mechanical lift were used to lift and raise Resident #195 back to the bed. Resident #195 was assessed for injury and there was no injury or bruising found on Resident #195's head. Resident #195 stated that her right leg hurt severely when touched and that her chest was hurting.

Review of the September 2024 Medication Administration Record (MAR) revealed an order to send Resident #195 to the hospital.

Review of an Emergency Medical Services (EMS) note dated 9/21/2024 revealed EMS was dispatched, routine (non-emergent) to the facility in reference to a fall/blunt force injury and acute respiratory distress involving Resident #195 at 6:32 am. EMS arrived on scene at 6:43 am, departed the facility at 7:07 am, and transferred

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 689	Continued From page 19	F 689		

care to the Hospital at 7:11 am. Oxygen was applied to Resident #195 at 6:46 am at a rate of 15 liters per non-rebreather mask. EMS documented vital signs at 6:51 am as blood pressure of 136/74, heart rate of 106 beats per minute, respiration rate of 17 breaths per minute, an oxygen saturation of 84% on 15 liters of oxygen per minute via non-rebreather, and a pain score of 0 on a scale of 0-10.

Review of the hospital record dated 9/21/2024 revealed Resident #195 arrived in the Emergency Department (ED) via EMS from the facility for evaluation after Resident #195 had a fall from the bed when an NA was trying to get her up to go to the bathroom that resulted in right hip and right shoulder pain. The NA also noted Resident #195 to be slightly more hypoxic than usual. Resident #195's right lower extremity was shortened and rotated with no significant pain to palpation. A computed tomography (CT, radiology scan) of the chest, abdomen, and pelvis dated 9/21/2024 revealed Resident #195 had pulmonary edema, right proximal femur fracture, right inferior/superior pubic rami (pelvis) fractures, and a questionable nondisplaced right sacral alar (lower spine) fracture, anasarca (generalized swelling), and chronic distal colonic distention (enlarge colon). Resident #195 was a poor surgical candidate due to her acute on chronic respiratory failure, urinary tract infection, and likely pneumonia. Resident #195 was placed on bilevel positive airway pressure (BiPAP, a non-invasive machine that helps with breathing). Resident #195 was admitted to the hospital under comfort care to manage symptoms. Resident #195 was given furosemide (medication used to treat fluid retention) and morphine (pain medication, also used to treat shortness of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 689	Continued From page 20	F 689		

breath) for air hunger (gasping for air), and was ordered a morphine intravenous (IV, medication given through the vein) continuous drip and lorazepam (medication used to treat anxiety and agitation). Resident #195 expired on 9/22/2024.

An interview was conducted on 11/7/2024 at 2:27 pm with NA #1. NA #1 stated she usually worked second shift (2:00 pm to 10:00 pm) and stated she had worked a "double shift" (2:00 pm until 7:00 am). NA #1 stated Resident #195 required two-person assist for all care and used a mechanical lift for transfers. NA #1 stated Resident #195 was not able to stand or help with turning and repositioning. NA #1 stated she had asked the Night Shift Supervisor before she started her round where NA #4 was because she needed help with her two-person assist residents. NA #1 stated she was told by the Night Shift Supervisor that NA #4 had been in and out of the building all night. NA #1 stated she proceeded to start her care rounds before shift change. NA #1 stated she should have waited for NA #4 to help her change Resident #195 but was not able to locate NA #4. NA #1 stated Resident #195 had had an incontinence episode and required a full bed change. NA #1 stated she rolled Resident #195 on her left side and had gone to the opposite side of the bed when the air mattress shifted, and Resident #195 rolled out of bed. NA #1 stated Resident #195's bed was approximately waist high, 2 foot off the ground. NA #1 stated she immediately left the room and alerted Nurse #3, who was passing medications on 100 hall and the Night Shift Supervisor, who was at the nurse's station. NA #1 stated Nurse #3 and the Night Shift Supervisor went to Resident #195's room and assessed her. NA #1 stated she observed Resident #195 to be in pain but could not specify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 689	Continued From page 21	F 689		

where. NA #1 stated the Night Shift Supervisor left the room to call EMS and Nurse #3 instructed her to get the mechanical lift and transfer Resident #195 into bed. NA #1 stated after she helped get Resident #195 back into bed, she finished her morning rounds while Nurse #3 remained with Resident #195.

An interview was conducted on 11/6/2024 at 8:36 am with NA #4. NA #4 stated that she worked on 9/21/2024 and was a floater (went between 100 and 300 halls). NA #4 stated she had worked with Resident #195 and stated she required two-person assistance, was bedridden, and not able to assist with any care. NA #4 stated she offered at the beginning of her shift to help NA #1 with her rounds, and NA #1 stated she did not need any assistance. NA #4 stated NA #1 stated, "I can do it myself with my eyes closed."

An interview was conducted on 11/5/2024 at 4:23 pm with Nurse #3. Nurse #3 stated she worked third shift (11:00 pm to 7:00 am) on 9/20/2024 and was assigned Resident #195. Nurse #3 stated Resident #195 required total care, was not able to do anything on her own, and required two-person assistance with all care. Nurse #3 stated NA #1 had approached the nurse's station close to shift change, around 6:15 am, on 9/21/2024 and stated Resident #195 was in the floor. Nurse #3 stated she took off running down the hall and when she arrived at Resident #195's room, Resident #195 was lying on her right side with her back facing the bathroom. Nurse #3 stated Resident #195's head and shoulders were underneath the bed. Nurse #3 stated she crawled under the bed where she was eye-to-eye with Resident #195 and assessed her head for any obvious trauma and did not see any external

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 689	Continued From page 22	F 689		

rotation or shortening of the right leg. Nurse #3 stated she assessed Resident #195 for bleeding, bruising, and deformities. Nurse #3 stated she obtained vital signs while Resident #195 was on the floor and noted Resident #195's oxygen saturation to be 82% at which time she increased Resident #195's supplemental oxygen from 2 to 3 liter per minute and was instructed by the Night Shift Charge Nurse to transfer Resident #195 back to bed utilizing the mechanical lift. Nurse #3 stated after Resident #195 was transferred to bed, she began to gasp for air. Nurse #3 stated she continued to monitor Resident #195 until EMS arrived. Nurse #3 stated NA #1 reported she was not able to find the NA#4 to help her and had tried to change Resident #195 by herself.

An interview was conducted on 11/7/2024 at 1:35 pm with the Night Shift Supervisor. The Night Shift Supervisor stated she was able to recall the incident with Resident #195 on 9/21/2024. The Night Shift Supervisor stated, close to shift change around 6:15 am, NA #1 approached the nurse's station and reported Resident #195 was on the floor. The Night Shift Supervisor stated she observed Resident #195 to be laying on her side between the wall and the bed. The Night Shift Supervisor stated she felt Resident 195's hips and felt no deformities. The Night Shift Supervisor stated she had not noticed any shortening or external rotation. The Night Shift Supervisor stated Nurse #3 instructed the NAs to transfer Resident #195 to bed and she left the room to call EMS.

An interview was conducted on 11/6/2024 at 10:32 am with the Hospitalist. The Hospitalist stated she cared for Resident #195 on 9/21/2024 after she arrived in the Emergency Department.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 689	Continued From page 23	F 689		

The Hospitalist stated she had only been told Resident #195 had been found in the floor and no additional details about the fall. The Hospitalist stated Resident #195 had a femur fracture and pelvic fractures but was a poor surgical candidate. The Hospitalist stated Resident #195's family opted for comfort care and Resident #195 was admitted, and later expired on 9/22/2024. The Hospitalist stated Resident #195 had a history of chronic respiratory failure and her cause of death was respiratory failure. The Hospitalist stated the fall on 9/21/2024 could have been a contributing factor because the pain associated with the fall could have led to worsening respiratory failure.

An interview was conducted on 11/5/2024 at 1:15 pm with the Funeral Home Representative. The Funeral Home Representative stated Resident #195's death certificate revealed she expired on 9/22/2024 at 9:25 am with the cause of death as respiratory failure.

An interview was conducted on 11/5/2024 at 4:53 pm with the Director of Nursing (DON). The DON stated NA #1 tried to change Resident #195 by herself. The DON stated after NA #1 had turned Resident #195 on her side, she walked around to the other side of the bed, at which time Resident #195 rolled out of bed. The DON stated Resident #195 was a two-person assist and NA #1 had tried to change Resident #195 on her own.

An interview was conducted on 11/7/2024 at 4:37 pm with the Administrator. The Administrator stated he had been notified NA #1 had tried to perform two-person assist incontinence care on her own, had positioned Resident #195 on her left side facing the sink, went around Resident #195's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 689	Continued From page 24	F 689		

bed to change the linens, and Resident #195 rolled off the bed. The Administrator stated staff reported she was screaming and demanded to be gotten up. The Administrator stated NA #1 should have gotten help before attempting to provide incontinence care for Resident #195.

The Administrator was notified of immediate jeopardy on 11/14/2024 at 6:15 pm.

The facility provided the following corrective action plan with a completion date of 9/25/2024:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 9/21/24 at approximately 6:15 am resident # 195, rolled from the bed onto the floor as Nurse Aide
(NA)#1 was providing incontinent care.

NA#1 was providing care to the resident without the assistance of another NA and walked to the other side of the bed after cleaning the resident and positioning resident on their side on an air mattress. When NA #1 reached the other side of the bed to finish changing the soiled linen, the weight of the resident depressed the air mattress and the resident rolled onto the floor in a face down position. The resident, who requires a mechanical lift for transfers, was yelling "help me, get me out of the floor". The resident was positioned partially under the bed so the nursing staff utilized a mechanical lift pad to slide her from under the bed and then a mechanical lift to get her back into the bed to assess and provide care. Prior to lifting the resident from the floor, the nurse #3 observed no injuries including external

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 689	Continued From page 25	F 689		

rotation of legs or leg length difference. The resident was transferred to the Emergency Room (ER). Physician was notified of fall by the charge nurse at 6:30 am on 9/21/24. EMS was called and resident was transferred to ER at approximately 6:30 am on 9/21/24.

Resident's first contact was called at approximately 6:20 with no answer on 9/21/24. Nurse #2 called the second contact after the resident was transferred and they indicated they were in the hospital, for an unrelated reason, and saw the resident being brought in.

Upon investigation by the DON on 9/21/2024, the following was determined:

NA#1 did not follow resident care guide of having 2 people assist although there were two other CNAs working the hall.

A root-cause analysis completed by the DON on 9/21/2024 revealed the cause of the fall to be NA #1 not having assistance with providing resident incontinent care for a resident on an air mattress and dependent for bed mobility.

Address how the facility will identify other residents that have the potential to be affected by the same deficient practice:

All residents who are dependent for bed mobility, and those on air mattresses, have the potential to be affected. The DON and designee completed an audit of all resident's orders, mechanical lift use, progress notes, and air mattress user list and determined that those who are dependent for bed mobility and those on air mattresses, have the potential to be affected. Completed 9/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 689	Continued From page 26	F 689		

Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:

NA #1 was suspended by the DON from 9/21/24, after the incident, until 9/25/2024. NA #1 met with the DON on 9/23/24 and was given a final warning for failure to follow facility practice/use of care guide. NA #1 was re-educated on 9/23/2024 by the DON. Re-education included: checking care guide at the beginning of each shift to determine level of assistance required, requesting assistance when appropriate, notifying charge nurse if another NA refuses to assist, not positioning a resident on their side on edge of bed and going to other side without another staff member present to keep the resident from rolling to floor, use of two people assistance with air mattresses, and that two person assistance must always be used for mechanical lifts.

On 9/24/2024, the SDC had NA #1 return to the facility. NA#1 completed a demonstration of competency on providing care to a resident who is dependent for bed mobility. A skills competency sheet was also completed with employee on 9/24/204 by SDC. NA#1 was not allowed to return to work until completed. Completed 9/24/2024 by DON and SDC.

100% of NAs and Nurses were in-serviced on facility practice regarding use of the care guide for determining level of assistance with ADLS. Staff were instructed that they must check the care guide in the closet of each resident room to determine how many staff members needed to assist and ask for that assistance. If for any reason assistance was not available or refused

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 689	Continued From page 27	F 689		

the NAs were to report to the charge nurse who would assist or direct another staff member to assist. Staff were educated that they must never leave a resident lying on their side on the edge of the bed without a second staff present to prevent a fall from the bed. Staff were in-serviced that an air mattress might collapse if the resident was positioned on the edge of the mattress and therefore no resident could be left unattended to go to the other side. Staff were specifically educated by the DON that they must use two-person assistance for anyone using an air mattress. Staff were also educated that two-person assistance is always required on any type of mechanical lifts. Any staff member that was not able to be in-serviced on this date will not be allowed to return to work until they have received the education. DON and SDC taught in small groups. Completed 9/23/2024

Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur:

SDC or designee will ensure that new hires and agency staff receive training upon hire on utilizing the care guide to determine level of assistance, not leaving a resident unassisted on their side on the opposite side of the bed from where they are working and using two- person assistance for all residents who are dependent for bed mobility, on air mattresses and using mechanical lifts. Completed 9/23/2024

100% of NA's and Nurses were in-serviced on facility practice regarding use of the care guide for determining level of assistance with ADLS. Staff were instructed that they must check the care guide in the closet of each resident room to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 689	Continued From page 28	F 689		

determine how many staff members needed to assist and ask for that assistance. If for any reason assistance was not available, or refused, the NAs were to report to the charge nurse who would assist or direct another staff member to assist. Staff were educated that they must never leave a resident lying on their side on the edge of the bed without a second staff present to prevent a fall from the bed. Staff were in-serviced that an air mattress might collapse if the resident was positioned on the edge of the mattress and therefore no resident could be left unattended to go to the other side. Staff were specifically educated that they must use two- person assistance for anyone using an air mattress. Staff were also educated that two-person assistance is always required on any type of mechanical lifts. Any staff member that was not able to be in-serviced on this date will not be allowed to return to work until they have received the education. By the SDC and DON using small groups. Completed 9/23/2024

During orientation, new hires and agency will be trained by the SDC or designee regarding use of the care guide for determining level of assistance with ADLS, never leaving a resident lying on their side on the edge of the bed without a second staff present to prevent a fall from the bed, that an air mattress might collapse if the resident is positioned on the edge of the mattress and therefore no resident could be left unattended to go to the other side. Staff will be specifically educated that they must use two-person assistance for anyone using an air mattress or any type of mechanical lifts. Completed 9/23/24.

Care guides are present in the closet of each resident to communicate special needs between

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 689	Continued From page 29	F 689		

staff to promote continuity of care. Care guides should be reviewed before a staff member begins to work with a resident each day as care areas could change from day to day. Items on the care guide include assistance with ADLs, special devices for positioning including air mattress, splints, etc. They are updated by the administrative assistant after the review of all new orders, 24-hour report, and notes from the past 24 hours. This facility practice continues to be that the DON or designee notifies the administrative assistant of changes to make on the care guide on business days and as needed. This is a longstanding and ongoing process.

Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained and include dates when corrective action plan will be completed:

Nursing Admin will conduct skills checks on 10% of CNAs for proper use of two-person assistance for bed mobility and those on air mattresses weekly x4 weeks, monthly x 2 months, and quarterly x3 or until such time as no incidents of failure to comply with Facility policy are noted. Monitoring ongoing. Plan completed 9/23/2024.

The QA committee will review results monthly and modify actions as need. Monitoring ongoing. Plan completed 9/23/2024.

IJ removal date: 9/25/24

On onsite validation was conducted on 11/20/24. The facility's investigation was reviewed along with the root cause analysis. The initial audit of potentially affected other residents was reviewed with no concerns identified. The care guides in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 689	Continued From page 30 rooms of residents on the initial audit including residents on air mattress were verified to have the correct information posted in each resident room. Interviews with NAs and Nurses revealed that they had education in September 2024 and again November 2024 regarding safe bed mobility practices, how to turn a resident, how much staff each resident required, where the information was posted, and how often to review the information. Observations were conducted and revealed staff used two-people for incontinence care of dependent residents that utilized air mattresses. The interviews also revealed that staff were able to verbalize that if a staff member refused to assist with a two-person assistance resident that it should be reported and another staff member requested to assist with the care. The QA minutes were reviewed and included the plan put into place. The removal date of 09/25/24 was validated.	F 689		
F 695 SS=D	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, and facility staff and resident interviews, the facility failed to keep an oxygen concentrator filter free from dust and debris for 1 of 5 residents reviewed	F 695	Resident #15□s oxygen concentrator was immediately cleaned on 11/7/2024 by housekeeping when notified by the surveyor on 11/7/2024 at 1:58 pm	11/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 695	Continued From page 31 for oxygen (Resident #15). Findings included: Resident #15 was admitted to the facility on 12/06/21 with diagnoses that included heart failure, COPD, and other disorders of lung. A review of Resident #15's most recent quarterly Minimum Data Set assessment dated 08/31/24 revealed Resident #15 to be cognitively intact with no rejection of care. Resident #15 was coded as receiving oxygen therapy while a resident. A review of Resident #15's physician orders revealed the following: - Oxygen at 2 liters per minute via nasal cannula to maintain saturations above 90% for COPD - Check oxygen saturation twice daily due to COPD A review of Resident's care plan last updated on 08/31/24 revealed a care plan for respiratory risk related to COPD and the use of oxygen. Interventions included to administer oxygen as needed and monitor oxygen saturations as needed. An observation made of Resident #15 on 11/04/24 at 11:52 AM revealed her on the bed adjusting a blanket. Resident observed receiving oxygen via nasal cannula. An observation of Resident #15's oxygen concentrator at this time revealed filter to be caked with gray dust around the intake and filter. An additional observation made of Resident #15's oxygen concentrator on 11/07/24 at 12:32 PM revealed the concentrator to be in the same	F 695	All residents with oxygen concentrators have the potential to be affected. On 11/7/2024, the facility administrative assistant conducted an audit to create a list of residents with oxygen concentrators. On 11/8/2024, concentrators were assessed by the housekeeping supervisor and cleaned as needed. On, 11/14/2024, 100% of housekeepers were in-serviced by the housekeeping supervisor on observing oxygen concentrators and cleaning on a weekly basis. No housekeeper was permitted to return to work until in-serviced. New hires will receive the same in-service by the housekeeping supervisor. All concentrators will be cleaned by housekeeping weekly. The housekeeping supervisor, or designee, will audit, beginning week of 11/18/2024, oxygen concentrators weekly for four weeks, and monthly for 4 months, to ensure they are being cleaned weekly. Results will be reported to QA and modifications made to the audit schedule if any concentrators are found unclean.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 695	Continued From page 32	F 695		

condition as it was observed on 11/04/24 with gray dust caked around the intake and the filter.

An interview with Nurse Aide (NA) #1 on 11/07/24 at 12:49 PM revealed she did not clean or have anything to do with resident oxygen concentrators. She stated she was unaware who was responsible for ensuring that oxygen concentrators remained clean and free from dust and debris.

An interview with NA #2 on 11/07/24 at 1:02 PM revealed the only responsibility she believed that nurse aides had regarding oxygen and oxygen concentrators was changing the tubing once a week or as needed. She stated she believed that it was the hall nurse's responsibility for ensuring that oxygen concentrators were clean and free from dust and debris.

An interview with Nurse #1 on 11/07/24 at 1:12 PM revealed she did not know who was responsible for ensuring oxygen concentrators were clean from dust and debris, but that she did not believe it was the responsibility of the hall nurses. She stated she knew that Central Supply took oxygen concentrators when they changed ownership and ensured they were clean and prepared for the next resident who would use it.

An interview with Central Supply on 11/07/24 at 1:43 PM revealed department heads were scheduled to do daily rounds on all residents admitted to the facility and part of those rounds was to ensure that oxygen concentrators were clean and free from dust and debris and that they were operating properly. She continued, stating when she observed an oxygen concentrator that was dirty and in need of cleaning, she would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 695	Continued From page 33	F 695		

notify the housekeeping staff, who would take a small brush and clean out the intake.

An observation of Resident #15's oxygen concentrator with Central Supply on 11/07/27 at 1:48 PM revealed Resident #15's oxygen concentrator to continue to be caked around the intake and filter with gray dust. Central Supply reported at this time that Medical Records was the department head that had Resident #15 on her daily rounds and stated the condition of Resident #15's oxygen concentrator was dirty and in need of cleaning.

An interview with Medical Records on 11/07/24 at 1:54 PM revealed she was the department head that was responsible for daily rounds on Resident #15's room. She stated when she would go into resident rooms, she would observe to see if the room was clean and in good condition. She reported she would observe the oxygen concentrator, and she would run her hand along the filter and intake to wipe away any dirt or dust build up. She reported she did not get down eye level with the concentrator and view the intake or filter to ensure it was clean and free from debris.

An observation of Resident #15's oxygen concentrator was completed with Medical Records on 11/07/24 at 1:55 PM. Resident #15's oxygen concentrator continued to be caked with gray dust and debris around the intake and the filter. Medical Records agreed that the intake and filter was dirty and in need of cleaning. She stated housekeeping needed to come in with a brush and clean out the intake and filter.

An interview with the Environmental Services Director on 11/07/24 at 1:56 PM revealed his staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 695	Continued From page 34	F 695		

was responsible for cleaning oxygen concentrators and ensuring the filters and intake were free from dust and debris. He reported that his staff should check concentrators when they are cleaning resident rooms and remove any dust buildup from the oxygen concentrators.

During an observation of Resident #15's oxygen concentrator with the Environmental Services Director on 11/07/24 at 1:58 revealed Resident #15's oxygen concentrator continued to be caked with gray dust and debris around the intake and the filter. The Environmental Services Director acknowledged the filter and intake were dirty and in need of cleaning, reporting "that should probably be cleaned by us. We can take a small brush and get that cleaned out." The Environmental Services Director indicated he would get his staff to clean the intake and filter immediately.

During an interview with the Director of Nursing on 11/07/24 at 3:43 PM, revealed she believed it was ultimately the responsibility of the housekeeping staff to ensure that there was no dust or debris buildup on resident oxygen concentrators. She indicated she expected dirty oxygen concentrators to be identified during the department head rounds and cleaned. She expected oxygen concentrators to remain free from dust and debris buildup.

During an interview with the Administrator on 11/07/24 at 4:57 PM revealed he was made aware of the dirty oxygen concentrator and that he expected oxygen concentrators to be checked at least weekly and to be cleaned by his housekeeping staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 726	Continued From page 35	F 726		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to verify that a Nurse Aide (NA) was competent in providing care for a dependent resident. Resident #195 rolled out of bed and	F 726	A skills checklist was completed by the SDC with the affected CNA, NA#1, on 9/24/2024. All CNAs have the potential to be affected	11/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 726	Continued From page 36 sustained a right femur (long bone of the upper leg), right inferior and superior pubic rami (pelvic) fractures and questionable nondisplaced sacral alar (lower spine) fracture during care. Resident #195 was a poor surgical candidate and was admitted to the hospital for comfort care. Resident #195 died on 9/22/2024. The deficient practice occurred for 1 of 6 NAs (NA #1) reviewed for competencies. Immediate jeopardy began on 9/21/2024 when NA #1 performed care without competencies being verified Resident #195 rolled off the side of the bed. Immediate jeopardy was removed on 11/19/2024 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems put into place are effective. The findings included: This tag is cross-referred to: F689: Based on observations, record review, staff, Nurse Practitioner, Funeral Home Representative and Hospitalist interviews the facility failed to provide care in a safe manner. On 9/21/2024 Nurse Aide (NA) #1 was performing incontinence care for Resident #195 who was resting on an air mattress raised to waist height and rolled Resident #195 on her side away from NA #1 who proceeded to walk around to the other side of the bed at which time the air mattress decompressed. Resident #195 rolled off the side of the bed to the floor and was wedged between	F 726	therefore an audit was initiated by the DON on 9/23/24 of all CNA files to determine if checklists were present. The Director of Nursing (DON) educated the SDC on 9/23/2024 that she must make sure that the On Hire Skills Checklist is completed and filed on hire for all nursing staff. The SDC will place, for all new CNA hires, the On Hire Skills Checklist in an employee file with the employee's name and date of hire. This will be maintained in the SDC office. No CNA will be allowed to begin work unless completed. The SDC and the DON completed an annual education fair and skills checklist training for 100% of CNAS on 11/16-11/18/2024, to ensure that all CNAS had a current skills checklist. No CNA was allowed to return to work until completed. A monitoring tool checklist, created by the administrator, was implemented to track that the On Hire Skill Checklist was filed on hire and that annual training was provided with the date note. The checklist will be maintained by the SDC. The administrator will review the files of new hires weekly x4, monthly x 3 to ensure completed. Any concerns will be addressed in QA and modifications made.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

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F 726	Continued From page 37	F 726		

the bed and the wall. Resident #195 was transferred to the hospital where she was diagnosed with a right femur fracture, right inferior and superior pubic rami (pelvic) fractures, questionable nondisplaced sacral alar (lower spine) fracture. Resident #195 was a poor surgical candidate and was admitted to the hospital for comfort care. Resident #195 died on 9/22/2024. The deficient practice affected 1 of 6 residents (Resident #195) reviewed for accidents.

Review of Nurse Aide (NA) #1's employee file revealed she had been hired on 3/7/2024. There was no evidence of a completed Nurse Aide Competency Checklist prior to 9/26/2024.

Review of a Nurse Aide Competency Checklist dated 9/26/2024 revealed NA #1 had completed all NA competencies.

An interview was conducted on 11/7/2024 at 2:27 pm with NA #1. NA #1 stated she was not able to recall what specific training or competencies she had completed upon hire.

An interview was conducted on 11/7/2024 at 10:43 am with the Staff Development Coordinator (SDC). The SDC stated when an employee was hired, they were required to attend orientation and completed 3 days on the floor with a preceptor at which time the preceptor would sign off on skills completed on the Nurse Aide Competency Checklist. The SDC stated NAs should have completed all competencies prior to taking an assignment by themselves. The SDC stated she or the Scheduler reviewed the competencies before new staff were taken off orientation to ensure that all the skills on the Nurse Aide Competency Checklist had been completed. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

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MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

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F 726	Continued From page 38	F 726		

SDC stated she had no record of NA #1's competencies and stated she did not think that NA #1 had ever turned them back in. The SDC stated she was not sure how she had overlooked it. The SDC stated NA #1 should have completed all competencies after she was hired, prior to taking a resident assignment on her own. The SDC stated she was newer in her role and had not had any official training for the SDC position. The SDC stated she had NA #1 complete all NA competencies on 9/26/2024 after the incident with Resident #195.

An interview was conducted on 11/7/2024 at 4:11 pm with the Director of Nursing (DON). The DON stated competencies should be completed during orientation for new employees. The DON stated the SDC should ensure that all items on the Nurse Aide Competency Checklist were completed and signed off on by a preceptor. The DON stated she was not sure why NA #1's competencies had not been completed before the incident with Resident #195 and stated she should have had her competencies verified prior to taking an assignment on her own.

The Administrator was notified of immediate jeopardy on 11/14/2024 at 6:15 pm.

The facility provided the following credible allegation of immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

NA #1, who was hired on 3/7/2024, had skills competency completed on hire and signed off by mentors, but the employee misplaced the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

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F 726	Continued From page 39	F 726		

checklist before returning it to the SDC for filing.

The Staff Development Coordinator (SDC) did not ensure that the skills checklist was placed in the file for NA #1.

An audit of nursing staff employee files was initiated by the Director of Nursing (DON) who recalled, and confirmed through observation during her audit, that the previous owner had taken all personnel files during the change of ownership. The facility is unable to reach or request records from the previous owner. The ownership change was in 2005 and there are 23 employees who have been there longer than 2005. The audit further revealed that due to turnover of four SDCs in the past four years, and a change of offices, that an appropriate filing system had not been maintained for the On Hire Skills Checklist. Audit completed 11/15/2024

All residents have the potential to be affected.

All nursing staff have the potential to be affected.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

NA #1 was counseled and re-educated on 9/23/2024 by the DON. Re-education included: checking care guide at the beginning of each shift to determine level of assistance required, requesting assistance when appropriate, notifying charge nurse if another NA refuses to assist, not positioning a resident on their side on the edge of the bed and going to other side without another staff member present to keep the resident from

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	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

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F 726	Continued From page 40	F 726		

rolling to floor, use of two people assistance with air mattresses, and that two-person assistance must always be used for mechanical lifts. Completed 9/23/2024

100% of NAs and Nurses were in-serviced on facility practice regarding use other care guide for determining level of assistance with ADLS. Staff were instructed that they must check the care guide in the closet of each resident room to determine how many staff members needed to assist and ask for that assistance. If for any reason assistance was not available, or refused, the NAs were to report to the charge nurse who would assist or direct another staff member to assist. Staff were educated that they must never leave a resident lying on their side on the edge of the bed without a second staff present to prevent a fall from the bed. Staff were in-serviced that an air mattress might collapse If the resident was positioned on the edge of the mattress and therefore no resident could be left unattended to go to the other side. Staff were specifically educated that they must use two-person assistance for anyone using an air mattress. Staff were also educated that two-person assistance is always required on any type of mechanical lifts. Any staff member that was not able to be in-serviced on this date will not be allowed to return to work until they have received the education. By the SDC and DON using small groups. Completed 9/23/2024

On 9/24/2024 he SDC took NA#1 to a room and had her complete a return demonstration on providing care to a dependent resident in the bed. NA#1 was not allowed to return to work until all of this was completed. Completed 9/24/2024 by SDC.

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F 726	Continued From page 41	F 726		

A skills checklist was completed with NA#1 on 9/24/2024 with the SDC. NA#1 was not allowed to return to work until this was completed. She returned to work on 9/25/2024. Completed 9/24/2024

On 9/23/2024 the DON asked the SDC about the On Hire skills checklist for NA#1. The SDC informed there was not one in the file and that NA #1 stated she had misplaced it before turning it in. The DON educated the SDC there must be a skills checklist on file for all new hires from that date forward. From 9/23/2024 to present there have been 2 hires. Both have On Hire Skills Checklists in their file. No new hire will be allowed to begin work without a completed skills checklist. Completed 9/23/2024

Due to the removal of On Hire Skills Checklist by the previous owner, and files being misfiled by turnover in SDC position, the facility will redo on hire skills checklists for all employees beginning 11/16/2024 and ending 11/18/2024. No CNA or nurse will be allowed to return to work after 11/18/2024 if they have not completed the on hire skills checklist. This will be completed by DON, SDC or designee. Completion 11/18/2024

The categories of skills on the checklist are infection control, pressure ulcer prevention, nutrition, ADLs, documentation, patient satisfaction, safety (which includes use of lifts, two-person assistance for air mattress, total dependence, turning resident toward oneself for care).

The Director of Nursing (DON) had the SDC sign an in-service form documenting that she was told

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

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F 726	Continued From page 42	F 726		

on 9/23/2024 that she must make sure that the On Hire Skills Checklist is completed and filed on hire for all nursing staff. Training completed 9/23/2024. Form signed 11/7/2024. The SDC will place, for all new hires, the On Hire Skills Checklist in an employee file with the employee's name and date of hire. This will be maintained in the SDC office. No employee will be allowed to begin work unless completed. Completed 9/23/2024

A monitoring tool checklist, created by the Administrator, was implemented to track that the On Hire Skill Checklist was filed on hire and that annual training was provided with the date note. The checklist will be maintained by the SDC. Completed 11/15/2024

The Administrator is responsible for the plan.

Date of IJ removal: 11/19/2024

An onsite validation was conducted on 11/20/24. A review of documentation revealed skills checklists for all employees from 11/16/2024 through 11/18/2024 had been updated/completed that included the following: infection control, pressure ulcer prevention, nutrition, activities of daily living (ADL), documentation, resident satisfaction, safety, totally dependent resident care, turning and repositioning a resident towards oneself for care, and the use of the care guide for determining the level of assistance a resident required and that if a staff member refused to assist with a two-person assistance resident that it should be reported and another staff member requested to assist with the care. A review of an in-service revealed the Staff Development Coordinator (SDC) had been educated about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

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F 726	Continued From page 43 ensuring the On Hire Skills Checklist had been completed and filed for all nursing staff, an employee file will be maintained in the SDC office, and staff would not be allowed to work until the checklist had been completed. The facility completed On Hire Skills Checklists for all staff. The facility's monitoring tool checklist was reviewed and had been implemented and was being maintained by the SDC. The IJ removal date of 11/19/2024 was validated.	F 726		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(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(h) Medical records. §483.70(h)(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(h)(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	F 842		12/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

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F 842	Continued From page 44	F 842		

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 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(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(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(h)(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.

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	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

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F 842	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure accurate medical records when a resident's medication administration was incorrectly documented as administered for 1 of 2 residents (Resident #85) reviewed for medical record accuracy. The findings included: Resident #85 was admitted to the facility on 6/7/2021with diagnoses which included diabetes. Review of an order dated 10/1/2024 revealed Resident #85 was ordered to be administered semaglutide (used to control blood sugar for Type 2 diabetics) 0.5 mg subcutaneously once a week, on Sundays. Review of the November 2024 Medication Administration Record (MAR) revealed semaglutide 0.5 mg was documented as administered on Sunday,11/3/2024 at 8:00 pm by Nurse #2. An interview was conducted on 11/6/2024 at 3:28 pm with Nurse #2. Nurse #2 stated she worked night shift (7:00 pm to 7:00 am) on 11/3/2024 and was assigned Resident #85. Nurse #2 stated she had documented that she had given Resident #85 semaglutide on 11/3/2024, however when she had gotten to Resident #85's bedside, she realized there was not an adequate amount of medication in the pen to give the correct dose. Nurse #2 stated she had forgotten to go back and circle the medication administration on the MAR on 11/3/2024 at 8:00 pm to indicate that the medication was not administered.	F 842	Resident #85□s medication administration record was corrected to reflect the medication was not administered. Nurse #2 was in-serviced on the need to make sure all medication administration records are accurate by the DON on 11/6/2024. The DON collaborated with the nursing staff and reviewed records on 11/6/2024 and determined that all residents receiving medications have the potential to be affected. 100% of nurses and med-aides were in-serviced by the DON and SDC completed 12/9/2024 and com regarding the need to make sure all medication administration records are accurate and specifically, if a medication is not administered that it be circled and noted on the back of the MAR as to why. This will be part of new employee orientation beginning 11/13/2024 The DON, or designee, will review 10% of Medication Administration Records (MARs), beginning week of 12/9/2024, weekly x 4 and monthly x3 to determine if documentation is accurate. Results will be discussed in QA and modifications made to the plan if there are any discrepancies.	

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	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

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F 842	Continued From page 46 An interview was conducted on 11/5/2024 at 2:44 pm with the Nurse Supervisor. The Nurse Supervisor stated she was approached by Resident #85 on 11/5/2024. The Nurse Supervisor stated Resident #85 told her she had not gotten her semaglutide on 11/3/2024. The Nurse Supervisor stated she immediately called Nurse #2. The Nurse Supervisor stated Nurse #2 had told her she had documented the medication as administered and when she arrived in Resident #85's room to administer the medication, she realized there was not an adequate amount to give the correct dose. An interview was conducted on 11/7/2024 at 4:01 pm with the Director of Nursing (DON). The DON stated Resident #85 had informed the Nurse Supervisor she had not received her semaglutide. The DON stated the Nurse Supervisor called Nurse #2 and was told there was not enough medication in the pen to give the appropriate dose. The DON stated Nurse #2 should not have documented semaglutide as administered on 11/3/2024 at 8:00 pm and should have gone back and circled the medication if she was not able to give it.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		12/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

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F 880	Continued From page 47 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

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F 880	Continued From page 48 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with staff, the facility failed to follow their infection control policy and procedures regarding Enhanced Barrier Precautions during high-contact care activities for residents with a feeding tube (Resident #126) and wounds (Resident #68 and Resident #49). This failure occurred for 4 of 4 nursing staff observed for infection control practices (Nurse #4, Nurse Aide #1, Nurse Aide #2 and Infection Preventionist). Findings included: Review of the facility's Enhanced Barrier Precautions (EBP) policy and procedures dated 04/01/24 read in part, "EBP refer to an infection control intervention designed to reduce transmission of multidrug- resistant organisms (abbreviated as MDRO and refers to a type of bacteria that are resistant to one or more classes	F 880	The SDC and wound care consultant were affected by the deficient practice and were trained on the facility policy regarding EBP by the DON on 11/16-11/18/2024. Specifically, the training included what tasks required EBP, and when to implement EBP, which residents required the use of EBP, signage, and where supplies could be found. All staff who have direct resident contact have the potential to be affected. On 11/15/2024, the DON reviewed each department's job duties and determined that nursing, wound care consultant, and therapy departments were affected including nurse #4, NA #3, NA #2. 11/16-11/18/2024 all nursing staff and therapy, and wound care consultant were in-serviced. Specifically, the training included what tasks required EBP, the	

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	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

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F 880	Continued From page 49 of antibiotics) that employs targeted gown and gloves use during high contact resident care activities. High-contact resident care activities include wound care: any skin opening requiring a dressing and device care or use: central lines, urinary catheters, feeding tubes, and tracheostomy/ventilator tubes. An order for EBP will be obtained for residents with wounds or indwelling medical devices. Signage may be placed above the resident's head of bed and designate EBP in a way as to alert staff but maintain resident privacy, dignity and homelike environment. EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk." 1. Observations conducted of Resident #126's room on 11/04/24 at 11:33 AM and 11/05/24 at 3:10 PM revealed no EBP signage posted in the room or on the door. An observation on 11/06/24 at 10:04 AM revealed Resident #126 sitting up in his wheelchair receiving a fortified nutritional supplement via tube feeding. There was no EBP signage posted in Resident #126's room. On the door of Resident #126's room was a small, white piece of paper with the letters "EBP" and no other information. An observation of Resident #126's tube feeding care and subsequent interview was conducted with Nurse #4 on 11/06/24 at 10:18 AM. Nurse #4 sanitized her hands, donned gloves but no gown and cleaned Resident #126's feeding tube site. Nurse #4 applied a new gauze around the feeding tube site, flushed the feeding tube with	F 880	appropriate PPE that is required, and when to implement EBP, which residents required the use of EBP, signage, and where supplies could be found. EBP policy will be reviewed in orientation for all applicable new staff. The treatment nurse will place a resident with a new wound on EBP and the nursing team supervisor will place a resident on EBP who meets criteria such as MDRO, medical devices such as catheters and tube feeding. The SDC will review telephone orders and 24-hour report for the addition of any new devices, MDRO, wounds to ensure that residents have been place on EBP. The administrator created an audit tool to observe for signage, supplies, correct residents on EBP, and staff understanding of EBP policy. The audits, beginning week of 11/18/2024, will be conducted by the administrator, or designee, weekly for four weeks, and monthly for 4 months. Results will be reported to QA and modifications made to the audit schedule if any	

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	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

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F 880	Continued From page 50	F 880		

water and reconnected the tube feeding. When asked if Resident #126 was on any type of precautions, Nurse #4 replied "no." When Nurse #4 was shown the small, white piece of paper with the letters "EBP" posted on Resident #126's door, Nurse #4 stated she had not noticed the sign and no one had informed her that Resident #126 was on EBP. Nurse #4 explained EBP was used for residents who had wounds or COVID-19. Nurse #4 stated the sign did not include any instructions on what PPE needed to be worn and usually there was a PPE cart out by the door when it was something that staff needed to do.

During an interview on 11/06/24 at 11:38 AM, the Infection Preventionist (IP) explained that staff received education about EBP during orientation and through an all-staff inservice conducted in April 2024. The IP stated staff were supposed to don a gown and gloves when a resident had an indwelling medical device such as a feeding tube. The IP stated when a resident was admitted to the facility, she reviewed their chart to see if EBP was required and placed an order at that time. The IP stated she, the Wound Care Nurse and/or the Nurse Supervisor placed precautionary signs on the outside of the resident's door and the "EBP" sign should have been placed on Resident #126's door when he transferred rooms. The IP stated PPE was kept on the linen carts on each hall for staff to use and staff should have been donning a gown and gloves when providing Resident #126 with high-contact resident care.

During an interview on 11/07/24 at 3:56 PM, the Director of Nursing (DON) revealed the admission nurse was responsible for placing orders for EBP when a resident was admitted with an indwelling medical device such as a

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F 880	Continued From page 51	F 880		

feeding tube. The DON stated if a resident was on EBP, there should be a sign posted outside of the resident's door or in the room over the resident's bed and PPE was stored on the linen carts on each hall for staff to use. The DON confirmed Resident #126 was on EBP due to him having a feeding tube and stated that staff should have been donning a gown and gloves when providing Resident #126 with high-contact resident care.

2. Review of an admission Minimum Data Set (MDS) dated 9/21/2024 revealed Resident #68 had one unstageable pressure ulcer with suspected deep tissue injury in evolution.

Review of a Wound Physician note dated 10/30/24 indicted the resident had a stage 3 pressure ulcer (full thickness skin loss) with with subcutaneous tissue damage and moderate serous drainage.

An observation was conducted on 11/5/2024 at 1:55 pm. Resident #68 did not have an Enhanced Barrier Precaution sign on her door. Nurse Aide (NA) #3 and NA #2 entered Resident #68's room, washed their hands, put on clean gloves, and proceeded to provided incontinence care.

An interview was conducted on 11/5/2024 at 2:21 pm with NA #3. NA #3 stated if a resident was on Enhanced Barrier Precautions (EBP), there would be precautions sign on the outside of their door. NA #3 stated gloves, a mask, hairnet, and shoe covers were used for Personal Protective Equipment (PPE) for residents on EBP. NA #3 stated she did not wear PPE other than gloves

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	345296	A. BUILDING _____ B. WING _____	C 11/20/2024

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F 880	Continued From page 52	F 880		

when she provided incontinence care for Resident #68 because there was no precaution sign on Resident #68's door.

An interview was conducted on 11/6/2024 at 2:05 pm with NA #2. NA #2 stated if a resident was on EBP, there should be a precaution sign and PPE cart outside of the resident's room. NA #2 stated EBP was used when a resident had a wound. NA #2 stated she was not sure why Resident #68 was not on EBP and stated she did not wear a gown because there was no precaution signage outside of her room.

An interview was conducted on 11/6/2024 at 11:45 am with the Infection Preventionist (IP). The IP stated staff were educated during orientation about EBP. The IP stated residents with wounds should be placed on EBP. The IP stated when a resident was admitted to the facility, she would review their chart to see if EBP were required and would place an order at that time. The IP stated she, the Wound Care Nurse, and or the Nurse Supervisor placed precautionary signs outside of the resident's door. The IP stated Resident #68 was not on EBP because her wound was not big enough. The IP stated a wound had to be "big" before the resident was placed on EBP. The IP stated PPE was kept on the linen carts on each hall.

An interview was conducted on 11/7/2024 at 4:05 pm with the Director of Nursing (DON). The DON stated the admission nurse was responsible for placing orders for EBP when a resident was admitted with a wound, catheter, tube feeding, intravenous (IV, medication infused through the vein) therapy, etc. The DON stated should be a sign outside of the resident's room or over their

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F 880	Continued From page 53	F 880		

bed if the resident was on EBP and PPE was on the linen carts on each hall. The DON stated Resident #68 did not require EBP because the wound had a small parameter.

3. A Minimum Data Set (MDS) annual assessment dated 07/06/2024 revealed Resident #49 had a stage 3 pressure ulcer.

An observation of wound care for Resident #49 was completed on 11/06/2024 at 8:28 AM. A cart with personal protective equipment (PPE) supplies was observed in the hall outside Resident #49's room. The Infection Preventionist (IP) Nurse and Wound Care Physician Assistant (PA) were observed using hand sanitizer prior to entering the resident's room. Upon entry to Resident #49's room a sign for EBP was observed on the wall above Resident #49's bed which instructed staff to wear gloves and gown for high contact resident care activities such as wound care involving any skin opening requiring a dressing. Both IP Nurse and Wound Care PA donned gloves. The IP Nurse conducted positioning of resident on the right side and assisted with wound care and redressing. Wound Care Physician Assistant performed measurement of pink tissue and wound care while wearing gloves. IP Nurse and Wound Care Physician Assistant failed to don a protective gown.

An interview was completed with the Wound Care Physician Assistant (PA) on 11/06/2024 at 8:45 AM. When asked if special precautions should be used for the wound care, he stated it is up to the facility. Wound Care PA acknowledged not seeing the EBP sign and not wearing a gown during the wound care to Resident #49.

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F 880	Continued From page 54 Interview with IP Nurse at 2:18 PM on 11/06/2024 revealed when she consulted North Carolina State Prevention of Infection Control and Epidemiology (NC SPICE), she was told staff did not need to wear a gown for wound care if the wound did not have drainage. She did not recall the name of the person she consulted at NC SPICE. At 4:08 PM on 11/07/2024 an interview was conducted with the Director of Nursing (DON) who reported she was aware that staff need to don gowns and gloves for wound care. DON revealed she was responsible for oversight and updating of the Infection Prevention policies and procedures. During an interview with the Administrator on 11/072024 at 4:46 PM, he was informed about the IP Nurse and Wound Care Physician Assistant not wearing a gown during wound care. The Administrator stated he was not aware of the CMS guidance /recommendations specific to EBP.	F 880		
F 945 SS=E	Infection Control Training CFR(s): 483.95(e) §483.95(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to follow their infection control policy	F 945	NA #9 and Nurses # 1, 4, 5 were trained on the facility policy regarding EBP by the	12/1/24

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F 945	Continued From page 55 and procedure to ensure: 1) facility staff received infection control training on Enhanced Barrier Precautions (EBP) to know what required EBP and when to implement EBP and/or 2) failed to communicate to facility staff which residents required the use of EBP for 4 of 4 nursing staff reviewed for infection control (Nurse Aide #9, Nurse #1, Nurse #4, and Nurse #5). This practice had the potential to affect all residents. Findings included: Review of the facility's Enhanced Barrier Precautions (EBP) policy and procedures dated 04/01/24 read in part, "a) all staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions, b) all staff receive training on high-risk activities and common organisms that require EBP, and c) the facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities." Review of the all-staff training EBP attendance sign-in sheets dated 04/25/24 revealed no signature from Nurse Aide #9, Nurse #1, Nurse #4, or Nurse #5 indicating they had received the education. During an interview on 11/06/24 at 10:05 AM, NA #9 revealed she was not familiar with EBP nor did she recall receiving any education on EBP. NA #9 stated she had not been informed of any residents on her assigned hall that required the use of EBP. NA #9 confirmed there was a resident on her assigned hall that had an	F 945	SDC on 11/16-11/18/2024. Specifically, the training included what tasks required EBP, and when to implement EBP, which residents required the use of EBP, signage, and where supplies could be found. All staff who have direct resident contact have the potential to be affected. On 11/15/2024, the DON reviewed each department□s job duties and determined that nursing, wound care consultant, and therapy departments were affected. 11/16-11/18/2024 all direct-care nursing staff were in-serviced including therapy, wound care consultant, dietary and activities. Specifically, the training included what tasks required EBP, what PPE is required, and when to implement EBP, which residents required the use of EBP, signage, and where supplies could be found. EBP policy will be reviewed in orientation for all applicable newly hired staff. The treatment nurse will place a resident with a new wound on EBP and the nursing team supervisor will place a resident on EBP who meets criteria such as MDRO, medical devices such as catheters and tube feeding. The SDC will review telephone orders and 24-hour report for the addition of any new devices, MDRO, wounds to ensure that residents have been place on EBP. The administrator created an audit tool to observe for signage, supplies, correct residents on EBP, and staff understanding of EBP policy. The audits, beginning 11/18/2024, will be conducted by the administrator, or designee, weekly for four weeks, and monthly for 4 months. Results	

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F 945	Continued From page 56	F 945		

indwelling medical device and stated she had not been informed the resident was on EBP. NA #9 explained there was no Personal Protective Equipment (PPE) cart out by the resident's door or in the room and usually there was if staff were required to use PPE.

During an interview on 11/06/24 at 10:18 AM, Nurse #4 revealed she was familiar with EBP and explained EBP was implemented when residents had wound(s) or COVID-19. Nurse #4 was not aware that EBP was required for residents with indwelling medical devices. Nurse #4 confirmed there was a resident on her assigned hall that had an indwelling medical device but no one had let her know the resident was on EBP. She explained there was no PPE cart out by the resident's door or in the room and usually there was if it was something staff were required to use.

During an interview on 11/06/24 at 3:05 PM, Nurse #5 revealed she had not been informed of which residents required the use of EBP.

During an interview on 11/07/24 at 9:52 AM, Nurse #1 revealed she was familiar with EBP but had not received any training from the facility regarding EBP.

During an interview on 11/06/24 at 11:38 AM, the Infection Preventionist (IP) explained that staff received education about EBP during orientation and through an all-staff inservice conducted in April 2024. The IP stated staff were instructed to don a gown and gloves during high-contact care activities for residents on EBP. The IP explained PPE carts did not have to be out by each room as long as the PPE was close for staff to access and

will be reported to QA and modifications made to the audit schedule if any

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F 945	Continued From page 57 PPE was available on the linen carts located on each resident hall. The IP explained she was told during her Infection Control training that it was ok to put a small sign on the resident's room that states "EBP" for dignity reasons and the sign did not need to include instructions as long as staff knew who was on EBP and where the PPE was located. The IP stated any nurse could educate staff on who required EBP and what PPE need to be worn. During an interview on 11/07/24 at 4:24 PM, the Administrator revealed staff had been educated on EBP when the guidelines first came into effect. He stated staff were instructed to don the appropriate PPE for residents who required the use of EBP when providing high-contact resident care. The Administrator explained with all the different types of precautions, he felt confusion was a contributing factor with staff reporting they were unaware of EBP.	F 945		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may	F 947		11/20/24

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F 947	Continued From page 58 address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide required dementia and/or abuse training for 6 of 6 (Nurse Aide #1, #2, #3, #5, #6, and #7) reviewed for training requirements. The findings included: a. Nurse Aide (NA) #1's hire date was 4/4/2013. The education record (November 2023-November 2024) from the Staff Development Coordinator (SDC) revealed NA #1 had no abuse training. b. NA #2's hire date was 10/28/1992. The education record (November 2023-November 2024) from the SDC revealed NA #2 had no documented abuse or dementia training. c. NA #3's hire date was 3/7/2024. The education record (November 2023-November 2024) from the SDC revealed NA #3 had no documented abuse or dementia training. d. NA #5's hire dated was 7/27/2022. The education record (November 2023-November 2024) from the SDC revealed NA #5 had no documented abuse or dementia training. e. NA #6's hire date was 2/29/2024. The education record (November 2023-November	F 947	The affected CNAs, NA's 1-6, received training on dementia and abuse 11/16-11/18/2024. All CNAS have the potential to be affected. A list of all CNAS was obtained by the DON from the scheduler on 11/15/2024. 100% of CNAS received training, by the SDC or DON, on abuse and dementia on 11/16-11/18/2024. No CNA was allowed to return to work without training. Training on dementia and abuse will be conducted twice per year by the SDC at an education fair to ensure that all employees have training at least annually, and on hire. A master list of signatures will be kept in a folder titled "Education Fair." The SDC will provide the administrator with the months that the education fair will be completed in the upcoming year. At the completion of each education fair, the administrator will compare a master signature list of those attending to those employed, to make sure 100% of CNAs have received the training at least annually. Any discrepancies will be discussed in QA and appropriate correction action taken.	

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F 947	Continued From page 59	F 947		

2024) from the SDC revealed NA #6 had no documented abuse or dementia training.

f. NA #7's hire date was 5/17/2022. The education record (November 2023-November 2024) from the SDC revealed NA #7 had no documented abuse or dementia training. There were no documented skills competencies for NA #7.

An interview was conducted on 11/7/2024 at 10:43 am with the SDC. The SDC stated had taken over the position at the beginning of the year, around March 2024, and stated she was not sure why the NAs had not had their required abuse and dementia training. The SDC stated that she was responsible for ensuring they had training but could not locate any records.

An interview was conducted on 11/7/2024 at 4:11 pm with the Director of Nursing (DON). The DON stated there had been a lot of change in the SDC role and she was not sure why the NAs had not had their required abuse and dementia training. The DON stated that skills competencies were supposed to be conducted during orientation and annually. The DON stated she was not sure why they had not been completed. The DON was not sure if the SDC had been informed about the responsibilities which included abuse and dementia training because there had been a lot of turnover in that position.