		D HUMAN SERVICES	1					D: 11/26/2013 M APPROVED
CENTER	RS FOR MEDICARE & I	MEDICAID SERVICES ·			:	1		0. 0938-0391
	OF DEFICIENCIÉS F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	* 5	(X2) MULTIF	1	ONSTRUCTION		E SURVEY PLETED
		10 mm 1 mm 2 mm 2 mm 2 mm 2 mm 2 mm 2 mm	8 6		7	CONTRACT NO.		С
		345172	- 	B. WING	5	· · · · · · · · · · · · · · · · · · ·		08/2013
NAME OF P	ROVIDER OR SUPPLIER		(d)		STR	SET ADDRESS, CITY, SYAYE, ZIP CODE		
TRIAD CA	RE AND REHABILITATIO	N CENTER				NORTH ELM STREET ()		
(X4) ID	BŮMMARY ŞTA	TEMENT OF DEFICIENCIES	100	. ZiD	7.	PROVIDER'S PLAN OF CORRECTION		(45)
PREFIX TAG		MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION 1	5	PREFIX	(<u>)</u> [(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION DAYE
1/1/0		oo Death tho M. Ormatica		TAG		CROSS-REFERENCED TO THE APPROPRIA	112	DATE
			71	1 25				·
F 221	483.13(a) RIGHT TO	DE EDEC EDOM		r 00		The filing of this plan of correction	ď	
5S=E		UTS	55.3	F 22	41	does not constitute an admission		
	, moione teamon				3			
,	The resident has the r	ight to be tree from any	3		-	the deficiencies alleged, did in faci		
		osed for purposes of			3	exist. This plan of correction is file	ed .	
		ice, and not required to ;	14			as evidence of the facility's desire	to	
	treat the resident's me	dical symptoms.	-5-1			comply with the regulations and to		
						provide high quality resident care.		
		1000 (1000) · · · · · · · · · · · · · · · · ·				provide night quality resident care.		
		is not met as evidenced.			Ì	rana.		
	by:				1 .	F221		
	Based on observation		11 0		37			•
		reviews the facility failed to			6	1. Residents #1, #23, #41, and #171		
		bed boisters, perimeter	5			had restraint/device evaluations		
		hair use for 4 of 4 sampled	1			completed on 12/2/2013. Each		ļ
	residents reviewed for		M. (-5		resident's care plan and RAI, if		
	(Resident # 1, #23, #4							
	Findings included:	The first the second second	11	*****	Ĉ.	needed, was updated to reflect the		1
	1. Resident #171 was	admitted originally on			;	resident's current condition and an	У	}
	6/21/2012 with diagnos					medical device/restraint in use.		- 1
	schizophrenia and den	nentia.						1
1		171's Minimum Data Set				2. A device evaluation will be		1
		indicated Resident #171		7 18.77.4		completed on all facility residents b	.	ļ
		ly impaired with impaired	yfi .			DNS/ADNS/Unit Managers by	' }	Ì
	#171 indicated sympto.	m memory. Resident		門際!1	*			1
.	trouble concentrating of	ns of depression daily,	VI -	35	١	12/06/13. Their RAI and plan of car		
		t#171 did not have any	3			will be updated to reflect the outcome	me	
						of the device evaluation and their	1	i
		ith personal hygiene, toilet				current status. The device evaluation	ın	
	use, dressing, and bed	mobility. Resident #171			- 1	· · · · · · · · · · · · · · · · · · ·	1	
1	was not coded as havir	ng restraints in place.	11	, <u>, , , , , , , , , , , , , , , , , , </u>	. 1	will be completed on new admission		
	A review of Resident #	171's medical record			.7.4	with quarterly, annual and change o	_ [İ
		ated 7/31/13 with at risk		11 P. A.	.	condition assessments. The residen	t's	
•	for falls related to impa	ired mobility as one of the				RAI and care plan will be updated		
1	locused problems. Inte	rventions in place were:	1		. 1	upon completion of the device		1
		to communicate presence	ij l'		- 1			
	of pain B. assist to reposition t	or constant	1		1	evaluation,	- 1	
		OF COMICIT	11, 1,	1 1 1			<u>_</u>	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		:	ND HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391
ſ	OF DEFICIENCIES	· .	(X1) PROVIDER/SUPPLIERA		(X2) MULTIP	LE CONSTRUCTION 3	(X3) DATE SURVEY
	FCORRECTION		IDENTIFICATION NUMB		A. BUILDING	アー・コン しょうはん がっこうな 蓋 しただい	COMPLETED
							C
		!	345172		B. WING		11/08/2013
NAME OF P	ROVIDER OR SUI	PLIER .			A	SYREET ADDRESS, CITY, STATE ZIP CODE	
TRIAD CA	REAND REHA	BILITATI	ON CENTER			707 NORTHELM STREET	
	<u> </u>	1	10 18 10 18 4	F 4		HIGH POINT, NC 27262	
(X4) ID PREFIX	(EACH	DEFICIENC	rayement of deficiencies) By Must be preceded by Fl	LLS	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	
TAG	REGUL	ATORY OR	LSC IDENTIFYING INFORMATION	5N)	TAG	CROSS REFERENCED TO THE APPROPRIA	
		·	ne serie	3d 3f		DEFIGIENCY)	
F 221	Continued F						
1 661	C. alarm to				F 22		į.
	D. alarm to		an .	rivi III	18 7	will audit newly admitted residents	E
	E. floor ma			海勒事。		charts within 72 hours to ensure th	1
	F. place in	open are				device evaluation has been comple	ted
			or increased falls			and care plan has been updated. T	he
			out of reach of resident's	ince		Clinical Reimbursement Coordinate	or'
	he turns the l. incontiner					will audit the resident's charts on a	ţ
	J. anti-slip p			4 3		quarterly and annual basis to ensur	į.
	K. ensure co			i i		the RAI and plan of care are	•
			when tired or agitated	田道。	,	comprehensive and accurate.	!
	M. perimete					comprehensive and accurate.	
	wheelchair w	hen rest	e out of bed up to lead less or agitated as resid	ent	rectors in a Realthy in	4. Residents who experience falls o	r .
	allows		January Control			other changes of condition will be	` <u> </u>
			ions as indicated		1	discussed and assessed daily in the	
			li-rollback bars to wheel	chair 👍			
1			ion slip footwear 🥖 🚉 use call light prior to			morning standup meeting by the ID	; ;
1. 21	embulating o			4	,	team, Care plan interventions will i)ē
			d, and ensure environm	ent ;	4	updated and implemented	
***************************************	is free of clut		生物 医多种 的复数			immediately as needed. A weekly	
}			sident#171 on 11/5/13 a esident in bed with a - ''		4 4 7	audit will be completed by the	[
ļ			esident in bed with a Resident #171 had only			Director of Nurses to ensure resider	nts
			en with his legs over the			who have had falls or changes in	
	edge of the n		without his feet touching			condition have had a fall assessmen	ıt,
-	floor.		The state of the s		14	device evaluation, RAI, if needed, ar	nd
			sident#171 on 11/6/13 a ssident who was dresse			updated plan of care completed and	
,			s waist up. The resident		١	signed off by the IDT team. Weekly	•
1	was restless	n bed ar	nd was attempting to get	out		audits will be conducted for 8 week	_
l	of the bed. T	ne resid	ent had his feet and legs	11.		the bi-weekly for 4 weeks. Results o	1 1
			erimeter mattress		The second	the audit will be reported during the	
			of bed. The bed alarm of nt was attempting to rai				1 1
			lge of the bed with his a			monthly Pl'meeting	12/06/13
i	and was unsu	ccessful	at getting out of bed. T	he 📑	-		
	resident then	laid bacl	к down ол his right side.	3			
RM CMS-2567	(02-99) Provious V	irsions Obse	riete Ew	ntio:50MJis	. Fa	citly 10 923288 1 1 continu	ration sheet Page 2 of 71
		•					
		٠.	THE STATE OF THE S				
		:			- 1 in 2		
						は、これには大きなできます。 1987年 - 1987年 - 19874年 - 1987年 - 1987	
				4. h		1、1、1年1月1日 日本学の教授を紹介しています。 1、1、1、1、1、1、1、1、1、1、1、1、1、1、1、1、1、1、1、	
		i		Ti (4)			
	,	: !		Y d		一种解析的影響情報和	•
		•				(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	
				31 3		一多期間結算[4]	

		ID HUMAN SERVICES							MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	vio	er e dige	17-3	1. (2.4. 8.)	\$ 1		0. 0938-0391
	OF DEFICIENCIES :	(X1) PROVIDER/SUPPLIER/CLIA IN IDENTIFICATION NUMBER:	(4) - (5) - (1)	(X2) MULTIPLE A. BUILDING	CONSTRUCTIO	N			SURVEY PLETED
		1	· .	្រុះ ម៉ូន្ទែក្រុំ		Jr 57 13		İ	С
		345172		B, WING		<u>ं। । । । । । । । । । । । । । । । । । । </u>			08/2013
NAME OF PI	ROVIDER OR SUPPLIER	一门靠在一只要连环就。	3		TREET ADDRES				
TRIAD CA	RE AND REHABILITATIO	ON CENTER	41		07 NORTH ELM				
			- 1		iigh point, n	IC 27262			
(X4) ID PREFIX TAĞ	(EACH DÈFICIENC	ATEMENT OF DEFICIENCIES A Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EAC	H CORRECTIVE REFERENCE	AN OF CORRECTION SHOULD TO THE APPROP	2 8 E	OX5) COMPLETION DATE
		Service Annual A	<u> 1</u>		# JA	TO EF	ICIENCY		
F 221	Continued From page	工具的基礎報報。 ■2.1.1.10011111基礎的版。	() ()	F 221					
		sident #171 Clinical at Risk	3						
		leeting Minutes Form dated		44.5	1.00	1 1 1 1 1 1 1 1			
		perimeter mattress was first		* * * * * * * * * * * * * * * * * * * *			9		
	implemented on 7/18		•	39 (A)		化类型	情格的		
		the form as to why this was	1	4	1				
		review of Resident #171's	-	. "			3		
	fall reports did not yie	lid a fell report dated 🖫 🚋	1:				ř		
	7/18/13.								
		e #9 was conducted on 🕟 🦠	. :						
		Aide #9 stated the perimeter	٠,		7.				
1		to keep the resident from	-3				g a		
		An interview with Nurse #5			44 - 5		1		
		77/13 at 7:30 AM. Nuise #5: nattress is being used to			1	10 (1)			
		n falling out of the bed.	£ 1	4 6	1 3 36				
		ducted with the Assist					•		
		DON) on 11/7/13 at 7:30	6.1			147条集	3		
		ed the perimeter mattresses	4			11. 数键			
		as restraints but to oue the	e (
	resident to not get ou	l of bed and to give the staff	Ş.	9 6 18	1000				
	" time to hopefully gal	t there in time before he 🚈 👵	No. 1). 		
11.5	does fall, "		4	100		16 17			
		ducted with the Regional	+1	1000			N		
		n 11/7/13 at 11:20 AM, 🔠 🔀				· 10 19 14 1	· 基 14 人。		
		he Regional Director		1	1 3 15				
		perimater mattress and:	1.						
		ident#171 were not		4			劉 任 111		
		ent because he is still falling	-1				£ .		
		er stated that the mattress			1	10 (1)			
		the 14 times he did since		1					
		into place. Upon further : ♦ .			The state of		\$		
	inquiry the Regional D	Director Consultant stated	*.*	1 (1)			£ .		ļ !
		ess were not reassessed to					i i		
		not decrease or increase	5.			17, 30, 24			ţ
1	Resident #17 i's falls.	二分批 化二唑酚 超	11				\$		j
	An interview with Aide	#8 was conducted on a second	:	0.0		11 1 1			
	11/8/13 at 6:30 AM. A	Nide #8 stated the perimeter	i				2		
ļ	bed was being used f	or Resident #171 was to			13.		ř.		1

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES	ij	n in 1994) Beria Lasseri				APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	j.			関 一つ 自然 論 法的 鎌鷹門 ターー		. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA. IDENTIFICATION NUMBER:	: <u>[</u>	(X2) MUL A. BUILDI	4.5	CONSTRUCTION	(X3) DATE	
	į	■ 人名英格兰人姓氏克勒克斯的变体。		1 ~ 00.00		The state of the s	1,	
		245172	·;	B. WNG	1		(3
MAILE OF N	DO ANTO AN AUGOURA	345172					11/0	8/2013
NAME OF M	ROVIDER OR SUPPLIER		÷į			TREET ADDRESS, CITY, STATE, ZIP CODE		
TRIAD CA	RE AND REHABILITATIO	ON CENTER	19 1 15 1			OZ NORTH ELM STREET HIGH POINT, NC 27262		
(X4) ID		ATEMENT OF DEFICIENCIES AND A		ID.		PROVIDERS PLAN OF CORRECTION	N	(XS) GOMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL (1) LSC IDENTIFYING INFORMATION)		PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROP) BE]	GOMPLETION DATE
1733	I COOD HOLL OIL	4 5 20 3 21 32	10	TAG		DEFICIENCY)	NIVIE	¥7,113
			39	 	<u> </u>	10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
F 221	CANSAULI FLICALIA		¥.	1 2				
1 441	Continued From page				221]	
		n falling out of the bed.	•	2.0		1 的复数铁铁铁矿		
		ducted with Nurse #11 on) .					
		garding the general use of	- Fig. 1					
		s beds. Upon inquiry, Nurse ome of the residents had		7 7 7	• :			
		ers in place because.	: :			A New Control of the		
		get out of bed, " She	. 41					
•		ide rails could not be used,			- '			
		os may be used and that, "						
	the bolsters keep the		11.					
		ducted with the Director of		5,		1 人名英格兰人		
		Regional Director Consultant	1	e en last		★2000年前1000年前1000年		
		1. During this interview, the		1.40				
		on't use an assessment for		1		▲ 1000 - 1000		
		s not a restraint. "Upon 🛴						
	further inquiry regard	ing the reason for the use of	<u> </u>	7 6	4.		,	
	bolsters on a resident	t's bed, the Regional, 🚉 🦠 🧢		1		【名 医圆瓣 医髓囊囊炎		
1.1		idicated it was because the	-31		·	10 环避损的食物		
		out of bed. She stated that	- 11			The same of the sa		
	use of the bolsters, "	slows them down."	31					
		ducted with Nurse #17 on	Ŧ.,					
	11/8/13 at 2:45 PM. I					The state of the s		
		pleting the MDS and she		,	,	रीक के हुई बेंचे केव के	}	
		irses were responsible for	***					
		(Restraints) of the MDS	1	,				
		sked where this information indicated that when a	4					ĺ
		restraint, it would be	* **			The American Control of the Control		
		nt on a form under the "	-41					
		the resident 's medical	1			▼ 《新华塔 86 韓華所 》		
		iere would be an MD order		15	æ,	10 图形 計劃 建重工 1000		
		explain the reason for the	1					
	restraint, and it would	also be noted on the care	3 13 3 1			1 李磁道: (1) (4) (4) (4)		
l	plan when it was put i	into place. Nurse #17	1		٠.	To a 和/數字記集: [1] 10 10 10 10 10 10 10		
	reported that if a devi-	ce was assessed to be a 👈 .	1	[. ``#/	•	· · · · · · · · · · · · · · · · · · ·	}	
	restraint, it would be o	coded as such on the MDS					1	
	in Section P.		- 1				į	
	A follow-up interview	was conducted with Nurse					Į	
	#17 on 11/8/13 at 4:0	0 PM. 'During this interview,						

		ND HUMAN SERVICES (1)				FOR	M APPROV O. 0938-03
STATEMENT (OF DEFICIENCIES .	(X1) PROVIDER/SUPPLIER/CLIA	, ;		CONSTRUCTION	(X3) DATI	E SURVEY
viD FDW ())	CORRECTION	IDENTIFICATION NUMBER:		A BUILDING		ł	PLETED C
·•		345172	4	B. WING		i i	/08/2013
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TRIAD CA	RE AND REHABILITAT	ION CENTER			OT NORTH ELM STREET		•
(X4) ID PREFIX	SUMMARY S (FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL S	i la	ID PREFIX	PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SH		(XS) COMPLET)
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TÀG	CROSS REFERENCED TO THE APP DEFICIENCY)		DATE
٠.				3.0	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)		
F 221	Continued From pag			F 221			
,	she confirmed that t	he MDS nurse was not	Ų.				
	rasponsible for dete	mining whether or not a				-	
	urse up to the nurse	ed to be a restraint and that it managers to do that	ĵ			•	
		nducted with Nurse #15 on	·ì				
		Upon inquiry, Nurse #15	**				
		nagers for each unit were	; j.	# 3.5 2 1 1 1 1			
		pleting a restraint assessment	: -	4			
		nt who had a restraint. She	**	1,77			
-		sciplinary Team (IDT)	4				
ia se s	determined what wa	s considered a restraint and	4	: :			
•	what was not throug			**			
	An interview was con	nducted with the DON on	,			÷	
	11/8/13 at 4:34 PM,	Upon Inquiry, the DON stated	giri	1 1 16 14 1	医乳腺性 经转换运行		
	that if a resident was	having any kind of falls and	4				
		a restraint, the issue would	is 1				
	pe discussed in an i	DT meeting, a care meeting, sting. The meeting would	: -				
		esement and discussion			· 阿尔斯特 (1) 医克克曼 養 (1) (1)		
	among the team me		Н,	, i	1. 1. 16 15 15 15 15 15 15 15 15 15 15 15 15 15		
	assessment tool wor	uld be produced during this					
	meeting. The DON	indicated that if a resident	1				
	was determined to h	ave a restraint in place, a		45.4	[1] [1] [1] [1] [1] [1] [1] [1] [1] [1]		
	Written restraint asse	essment would be completed					
	and placed in the res	sident 's chart, 🔅 🔭 🧞 🔅	1	2.41.14			
	2. Resident# was a	admitted on 5/7/1999 with a	'i		10.00000000000000000000000000000000000		
	diagnosis of anoxio t	orain damage. Resident#1's	5				
[cumulative diagnosis	s included aphasia, dementia,					
	anxiety, depression,	and psycholic disorder.					
	A review of Resident	#1 's medical record	13 03	M. Gardin			
	but had not had a fall	t had a past history of falls	.				
[#1's Minimum Data Set		٠.	1. 新国民间,这名秦皇国。————————————————————————————————————		
.]	(MDS) dated 10/2/13	Indicated the resident was	: [4 / 1			
	totally dependent on	staff for activities of daily					1
j	living (ADL). The MI	OS stated Resident #1 was	,				ļ
]	amoulatory with one	person assist. The resident					
i	was not coded for us	e of restraints.	,				
	A review of Resident	#1's Clinical At Risk	1				
M CMS-2567	(02-99) Previous Volsions Ob	ecieta Eyent ID: 50	MINS	Fec	inty ID: 923288	continuation she	et Page 54
				7 8 4 6			orraga oc
	1		• .	10. 6			
-	1		7		(1) 数字数字数字数字	•	
* 2		4、主義「學學學」(2014年)	j, '	i garan		,	
		· (注) 经公司 () () () () () () () () () (4.	e de la composition della comp			
		化二环 數學的 经营养的 南	14. s		(1) 海 编码。 (1) 建建筑		
	ļ	化分子工作 医苯磺酰胺	,				
	į	The state of the section			1000 1000 1000 1000 1000 1000 1000 100		
	i .	· 人名英格兰 (146) · [18]			· · · · · · · · · · · · · · · · · · ·		
		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	4.				
	:	· "你说,我们就是快餐。"	## T	· · · · · · · · · · · · · · · · · · ·			

DOMESTIC HEADINGS

	3	AND HUMAN SERVICES & MEDICAID SERVICES				1 APPROV 1. 0938-03
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION:	(X3) DATE	
		一 对报告的 斯拉斯克克	i			5
		345172	B, WING	<u>李子一天被任何,比较的</u>		08/2013
NAME OF P	ROMDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP CODE		
TRIAD CA	RE AND REHABILITA	TION CENTER		707 NORTH ELM STREET HIGH POINT, NC 27252		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	* ib /	PROVIDER'S PLAN OF CORRECT	NOI	(X6) COMPLETK
PREFIX TAG	REGULATORY C	INCY MUST BE PRECEDED BY FULL A PROPERTY OF THE PROPERTY OF TH	PREFIX TAG	(ÉACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPRO	LD BE PRIATE	COMPLETE DATE
		(2) 10 日本計畫 (1) 2 日本計畫 (2) 2		DEFICIENCY		
				· 自己的 · 自己的		
F 221		- T	F 22	1		
) Meeting Minutes Form		· 1000 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)		
	Indicate there was	e CARE meeting on 8/2/12 but 🤌	1 36.57			
		ne meeting did not indicate.		[18] 等		
1 1		vas for. There was a notation		Jan 2018年2018年2018日		
		rules form that stated " 8/2/12				
		place and secured " . This was		▲ 「所有此」[[章][[章][[章][[章]]]		
	crossed out and wi	ritten below that was " nurses	1.55	1000 以 1000 次 1分量以 1000		
	to ensure safety pr	ecautions in place during		1 "哪点火烧精化"		
	round @ shift chan	ige " . The resident's last				
		s on 8/16/12 and concerned '				:
ì	Resident #1's biting	g of her fingers with				
	interventions of har	nd splints/ace wraps and a 🙏 🚽				
		placed on Resident #1	4		<i>:</i>	
	A review of Reside	nt #1's fall records indicated		Taring 被据《旅游集》50000		
	the resident had a	fall without injury on 8/2/12 at.		1 分提 异的 11		
	4:00 PM. The fall r	record included a notation		1 10 10 10 10 10 10 10 10 10 10 10 10 10		,
	under the heading	Describe the circumstances of	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
i	the event and what	t actions, if any, have been		1 · 多數學學數樣養疑念。		
	tákén lately. The n	otation read, "While walking		1、连编"的复数情况"。		
	past residents roon	n, saw resident sliding down		10 G 建键图图 4 图 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		
	off of right side of b	edelde, nurse ran to calch her		11 學過過到學園養養提出		
Į	but was unable to o	catch her and lower her to		1 产品和智慧和国家。		
1	floor, noted that sm	nall boosters were loosely		本人可能等的 经验过强 性医疗。	.	
	attached, full body	assessment done with no		1 水路沿岸外线 1		
		oted pain level 0 out of 10, bed		十分學 经增长的 清清日本	ļ	
[alarm did not sound	d, 2 cna's and 2 nurses put			ļ	
	resident in bed afte	r taking vital signs, bolsters		1 一点的情况待5000000000000000000000000000000000000		
	were attached tinht	ly and alarm was functioning. "		1、100000000000000000000000000000000000		
Į		er stated the resident's		【人工课 · 图 翻譯動,从一一		
	condition before ev	en/accident was confused,	The state of	1. 多端的 1. 14 16 16 16 16 16 16 16 16 16 16 16 16 16		
1	Under the heading	Fall Investigation/QA with a				
1	heading of Intrinsic	Factors with a definition of "	1	1 人名德利特 医乳腺囊膜炎 化		
I	Factors that are, me	ore or less, "built in" to the	1			
	resident. They ma	y Increase the risk of felling		1 对别的经验的		
ļ	and are generally n	ot modifiable. Intrinsic factors	1	1 多數: 你 经自己证券		
ŀ	consist of agerrelat	ed changes (changes in		1. (中海) (1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1		
1		t, musculoskeletal system &				
:		em, pathological conditions		事 一个细胞的复数 静静性 人名		
		onic disease). Emotional	1 1 1			
A CM8-2567	(02-99) Previous Versions ((1)	Withth, 03239		
·· 4140-5001	for only terring Africal C	Event (n) privil	rit F8	icisty ID: 923288	ante nottaunite	t Page 6
		人名斯特尔克 医多性髓肿的		(1) 1. [[] [] [] [] [] [] [] [] []		
		二十四十四個 的蜂變物的 点		10 · 17 · 128/19 (到1983) 11 · 1		
	· :.	一 经收益的				
	S 12 10	二十二世 经基础证券 第二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十				
	į	14 人物心臟腫瘍	$ \theta_{ij}\rangle = \frac{1}{2\pi} \frac{1}{2\pi} \frac{1}{2\pi} \frac{1}{2\pi} \frac{1}{2\pi}$	表一次 離る質 海外護 養殖 医二二		
	!	· · · · · · · · · · · · · · · · · · ·		李子 (6) 网络 一字名 (1) 第二十二十二		

C-18-201	3 09:52 From:TRIAD CARE	1	To:16103474725 Pase:8/71
	MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES		PRINTED: 11/28/2013 FORM APPROVED OMB NO. 0938-0391
STATEMENT (AND PLAN OF	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETED
·	345172		8. WING C 11/08/2013
	ROVIDER OR SUPPLIER RE AND REHABILITATION CENTER		SYREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET 1.7 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL T REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OFFICIENCY
F 221	Continued From page 6 issues, like fear of falling. Clinical conditions.		F 221
	such as Parkinson's disease, multiple scierosis, asthma, chronic obstructive pulmonary disease, osteoporosis, cancer, etc."		
	The form also listed just below the intrinsic factors a section with the heading Diagnosis/condition that may contribute with depression and other with check marks in the		
	boxes. There was a section with the heading Extrinsic Factors with a definition that stated "External".		
	forces that affect the resident. They have the potential to increase the risk of falling and are considered to be modifiable. External factors consist of the physical environment, the design of	No. of the case of	
	furnishings, the condition of ground surfaces and illuminations. In addition, devices used to promote mobility (walkers, wheelchairs) or guard	1	
11.10.2	against falls (mechanical restraints, bed ralls) trave been implicated in causing falls. Also, the type and condition of footwear worn by patients and residents can play a primary role in fall	11.11.11.11.11	
	causation. Medical conditions that affect mental status, such as delirium or infection, medications such as parcetice, analogsics digretice.	: 1	
	catharlics, cardiovascular drugs, or psychoactive drugs, " The extrinsic factors listed for the residents fall		
***************************************	were no footwear, bed alarm was not turned on, and the alarm did not sound. Under the heading interventions initiated immediately after fall it was stated "bolsters were tightened and bed alarm.		
	turned on." The Clinical Management Team determined that the fall was related to Resident i #1's cognition and further recommendations to	, 1	
	prevent further falls would be the "nurse to ensure safety precautions in place during rounds at shift change." Under the heading Root Cause Conclusion the		

		:		
-19-201	3 09:52 From:TRIAD CARE			To: 16103474725 Page: 9/71
10 601	S SSISE IT SIII. IKIAD CAKE THE MARKET			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	- 「大きな、大きな、株子、東京・東京・東京・東京・東京・東京・東京・東京・東京・東京・東京・東京・東京・東	i,		
DE54.07			4	PRINTED: 11/26/2013
	MENT OF HEALTH AND HUMAN SERVICES	:	341	FORM APPROVED
CENTER	S FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA; "	1	(X2) MULTIPLE	CONSTRUCTION (X3) DATE SURVEY
AND PLAN OF	CORRECTION IDENTIFICATION NUMBER:		A. BÜILDING	COMPLETED
	- 「「大きが時代函数を設定した	j -		经的连续经济的 医囊腺管 医多二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十
	345172		B. WING	11/08/2013
NAME OF P	ROVIDER OR SUPPLIER	-	.ş g	TREET ADDRESS, CITY, STATE, ZIP CODE
		i		07 NORTH ELM STREET 7 . 2
TRIAD CA	RE AND REHABILITATION CENTER	ij		IGH POINT, NC 27262
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL)	. •	S ID /: PREFIX	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DATE
		2		DEFICIENCY)
	1882年1983年,新福等、	7.		The Company of the Co
F 221	Continued From page 7		E nov	
		7	F 221	[1] [1] [1] [1] [1] [1] [1] [1] [1] [1]
11	intrinsic box was checked with a box below that			
· ** ±	With the heading Narrative Conclusion of Root		4	
	Cause with the statement that read "Resident	1		[4] [4] [4] [4] [4] [4] [4] [4] [4] [4]
	has a history of anoxic brain injury with explosure	ů.	-1	[1] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4
	personality disorder. Resident has impulsive			
	behaviors."		**	10 24 的 15 科教 的 1
	An observation of Resident #1 on 11/4/13 3:30			
	PM revealed the resident lying in bed, I the	}		
	supine position with a perimeter mattress that had			
	high winged sides and bed bolsters on either side			The American Control of the Control
7, 1	of the resident. The resident was not seen up out		11	[1] 医静物试验 藉滿自己 (1) [1] (1)
5.32	of bed on 11/4/13. Resident #1 was not able to			
	communicate her needs secondary to her		4	
	aphasia but was aware of her surroundings within			
	her room and made eye contact when spoken to	Ì		
	or when someone entered the room. The			[1] 1、 數量 [2] [2] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4
	residents call bell was within reach.		N Comme	
	An observation of Resident #1 on 11/5/13 at 2:30	*		
	PM noted the resident up in a rock and go chair]:		Company of the state of the sta
1	sitting in her room eating ice cream with Nurse		<u> </u>	(1) 使游戏员 建设置美国
1	[1	14.59	[4] (A. A. A. A. A. A. A. A. A. A. A. A. A.
• •	An observation of Resident #1 on 11/6/13 at 2:30. PM revealed the resident lying in bed with		ு த்	
,	halates is state as although lying in bed with		* *	· · · · · · · · · · · · · · · · · · ·
	bolsters in place on either side of her within a perimeter mattress.		that it.	
	perimeter mattress. An interview was conducted with Aide #8 on	9		
	An Interview was conducted with Aide #8 on 11/8/13 at 6:30 AM regarding the general use of	į.		
	bolster and perimeter mattresses on resident's			
	la la la la la la la la la la la la la l			
		!		多數 語音和音響音響性的
	incular. Aide till stoled the recidents with	:	31	[1] (中国) [1] [1] [1] [1] [1] [1] [1] [1] [1] [1]
	perimeter mattresses that have the high curved	۱	1 1	
1.	edges are being used to keep the recidents from	: 1	1.41	
		: [<u>'</u>	■ 一种的复数 發達性 5
	falling out of the beds also. Aide #8 could not explain why some residents have both the			
	bolsters with the perimeter mattresses.	3		
	An interview was conducted with Nurse #11 on		**	1. 多屬為自身模型的 1
	11/8/13 at 6:29 AM regarding the general use of	.		

DEPARTM	ient of Health Ai	ND HUMAN SERVICES	* * *	1.4-37		FORM APPROVED
CENTERS	FOR MEDICARE &	MEDICAID SERVICES	-11	4 11	<u>(一),是他们的人们有</u>	OMB NO. 0938-0391
STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION (OX3) DATE SURVEY COMPLETED
	!		- 111 -	, a poscomo	*	С
	!	345172	i 1	8. WNG		11/08/2013
NAME OF PR	OVIDER OR SUPPLIER	the material of the state of the			TREET ADDRESS, CITY, STATE, ZIP, CODE	
TRIAD CAR	RE AND REHABILITATI	ON CENTER			107 NORTH ELM STREET	
(X4) ID		TATEMENT OF DEFICIENCIES		* (D. 🔆 : 1	PROVIDER'S PLAN OF CORRECTION	¢×5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
1,00	NESOBILOTT OF		ab at	TAG	DEFICIENCY)	11.5
	<u> </u>		- 1) ··	9		
F 221	C				有一定 化砂油 建金管螺钉瓦 化二二	
- 1	Continued From pag	and the second of the second o	9 13	F 221	11. 在 就是一直的 装 数数2.5 。	
		s beds. Upon inquiry, Nurse	.)			
		ome of the residents had	1	5	The state of the s	
		tere in place because, 🐫 🔆 🧎	\$2.7			
		get out of bed." She	1			
		side rails could not be used,				
		ips may be used and that, "		The second		
	the bolsters keep the					
		nducted with the Director of Regional Director Consultant	37			
		M. During this interview, the	- 5		▲ 1000 1000 1000 1000 1000 1000 1000 10	
		on't use an assessment for	1			
		's not a restraint." Upon	15	1		
		ling the reason for the use of	3			
		it's bed, the Regional	- 1			
		indicated it was because the	- 51			
		out of bed. She stated that	1.11			j
		" slows them down: "40 the	· ·	4, ,		
		nducted with Nurse #17 on			101年 鐵路 365 新疆 2007	
		Nurse #17 shared				
		npleting the MDS and she				
		urses were responsible for	: \ :: ::::::::::::::::::::::::::::::::	Ne de la composition de la composition de la composition de la composition de la composition de la composition		
		(Restraints) of the MDS	- 1		上 一个人的数据建设的。	'
		asked where this information		1		1
		e indicated that when a 🛌 📑				
		a restraint, it would be	1.		1 · · · · · · · · · · · · · · · · · · ·	
	assessed as a restra	aint on a form under the "	1	ر زر		
	Assessment tạb " in	the resident's medical 💥 🧦		1.0		
		there would be an MD order,				
		explain the reason for the			上对于国际设施的基础	
		d also be noted on the care	哥		】 "不能的话"的表情意。	
		into place. Nurse #17	4		1 3 3 3 4 6 2 5 1 1 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	
		rice was assessed to be a	él.		1 一个分类的基础表现。	
		coded as such on the MDS	13		1 "黄鼠"的"黄连"的"	
I	in Section P.		1			
		was conducted with Nurse			1 人名英巴马斯勒尔	
		00 PM. During this interview,	i i			
		ne MDS nurse was not	14-		The state of the s	
		mining whether or not a	, old P		I Amit Walter	

	MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES				FORM): 11/26/2013 APPROVED
	OF DEFICIENCIES : (X1) PROMDER/SUPPLIER/CUA					, 0938-0391
	*CORRECTION IDENTIFICATION NUMBER: T		A BUILDING	CONSTRUCTION	(X3) DATE:	SURVEY LETED
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-11;	A BUILDING _	STORES STORES		
٠.	345 (72)	i.,	B, WING	· · · · · · · · · · · · · · · · · · ·	1	7
NAME OF P	ROVIDER OR SUPPLIER	-15.		TREET ADDRESS, CITY, STATE, ZIP CODE] 31/(08/2013
		- 11		OV. NORTH ELM STREET		
TRIAD CA	RE AND REHABILITATION CENTER			IIGH POINT, NC 27262		
		4			 , , , , , , , , , , , , , ,	
(X4) (D PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (**) (**) (**) (**) (**) (**) (**) (**		PREFIX	PROVIDER'S PLAY OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	- 1	TAG	CROSS REFERENCED TO THE APPROPR		DATE
		14		DEFICIENCY		
	2000 Can 12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			· (大海) (1) (1) (1) (1)		
F 221	Continued From page 9		F 221	医环腺性畸胎 医乳类连乳囊胚形 日本		į
5.1	was up to the nurse managers to do that		3 3 3			
	An interview was conducted with Nurse #15 on	- 17	4 2 3 4			
1.0	11/8/13 at 4:15 PM. Upon inquiry, Nurse #15		40.00			
	stated the nurse managers for each unit were	- 4 <u>1</u> 1 -				
	responsible for completing a restraint assessment	,				
	form for each resident who had a restraint. She	1				
	indicated the Interdisciplinary Team (IDT)	-	1.0	1 1870年 2 18 18 18 18 18 18 18 18 18 18 18 18 18		
	determined what was considered a restraint and					
	what was not through group discussion.	1				
	An interview was conducted with the DON on		2000		1	
٠. ز	11/8/13 at 4:34 PM. Upon inquiry, the DON stated					
	that if a resident was having any kind of falls and	4		and the state of t		
	there was a need for a restraint, the issue would	- 11:		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1		
	be discussed in an IDT meeting, a care meeting, and/or stand up meeting. The meeting would	2				
	involve a verbal assessment and discussion	4 14				
	among the team members. No written		1.0		1	
	assessment tool would be produced during this		1 8 July 1	19 1000多种的复数多种的	ļ	
	meeting. The DON indicated that if a resident	***				
	was determined to have a restraint in place, a	140				
	written restraint assessment would be completed	- 1	u , ,		Í	
	and placed in the resident's chart.	• •				
	3. Resident #23 was re-admitted from an acute.	adi Ali				i
	care hospital on 9/27/13 with a discharge					
	diagnosis of altered mental status likely.		11 -11 -1			
	secondary to aspiration pneumonia. His 🦸 💥	- 5				
	cumulative diagnoses included a history of	E i	**	· 《 像 他 标 精囊性》		
ļ	cerebrovascular accident (CVA or stroke) with					
Ì	dysphasia, dementia, and selzure disorder.	-1				i
	A review of the Resident #23's medical record revealed the patient had a history of falls, which	716				
	included a fall on 8/14/13. A Change of	- 4			ł	
1	Condition Documentation form dated 8/14/13				- 1	
	(time of day not indicated) included the following:	٠. ا				1
	narrative:			5. 一 数:60 g ()		
.	" CNA reports upon entering the room Rsd	i i				
1	(resident) was laying on the floor met. Nurse		_	1900年 美国		
1	assessed Red. Red denies pain no injuries		4			
	noted. Staff assisted Rad into geri-chair. Chair	- * - {		三 医偏性硬膜切迹		Į.

	MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES			PRINTED: 11/20/20 FORM APPROVI OMB NO, 0938-03	ED
STATEMENT (AND PLAN OF	OF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	A STATE OF THE STA	(X2) MULTIPL A. BUILDING B. WNG	PLE CONSTRUCTION (X3) DATE SURVEY COMPLETED C	
NAME OF P	ROMDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
TRIAU CA	RE AND REHABILITATION CENTER			707 NORTH ELM STREET HIGH POINT, NC 27262	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DATE	*
	10 00 7 5 8 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	- II. - 91		The Development of the Designation of the Designati	_
F 221	Continued From page 10	1			
1 221	alarm in place. Staff will continue to monitor		F 221		
	neuro (neurológical) checks in place.	v.	र्वे हेन्द्रकारी		
:: ;	A care meeting notation written in the	b_{h}			
	Interdisciplinary Progress Notes dated 8/20/13	3,			
	acknowledged the resident had a fall on 8/14/13	4	M		
	and stated, "Bed Bolsters placed on bed to alert				
	Res (resident) to boundaries. " A review of Resident #23's fall records indicated				
	the resident had a fall without injury on 10/2/13 at		1	1 2 次介,持續實際企	
	7:50 AM. The fall record included a notation	11	1		
	under the heading Describe the circumstances of	- 4			
	the event and what actions, if any, had been 1		4		
	taken lately. The notation read, "Staff				
	responded to resident bed alarm and saw	3			
	resident sliding to the floor in his room no apparent injury noted. "				
-	Resident #23's fall records indicated the resident	i J			
	had a fall without injury on 10/4/13 at 4:00 PM.	40.	No.		ł
	The Fall Investigation Records for 10/4/13	1			ŀ
	provided details of the event as follows:	6.1	* 1	1 · 图 · 图 · 图 · 图 · 图 · 图 · 图 · 图 · 图 ·	
	Interventions initiated immediately after fall:	-1			
	Resident was placed back to bed and	-			
	repositioned;		7 44.0		
	The Clinical Management Team determined that the fall was related to: Cognition (designated by	1	3 1		
	a chacked box);	41			
	Recommendations to prevent further falls:		·• ·· ·-		Į
	Staff is to ensure proper placement and				- 1
	positioning of bolsters to ensure comfort of				ł
	resident and therapy to evaluate and screen as			The state of the s	
1	moreateu.	e- 1			
	Summary of interview with witness(es): "S(aff heard bed alarm. Staff walked in room read at the sta	1			
1	and observed Rt (resident) hanging out of his bed		1 3 3		
	with knee on floor. Staff called for assistance and	: !,	1 0 2		Ì
	Rt was transferred back into his bed. Raised feet	(-) -(1)	10.	17 计数据控制数据 1	
'	of bed and repositioned Rt."				-
. }	Root cause conclusion: Intrinsic (designated by a		••		-
	checked box);			本の形式の次数機能のである。 	- 1

	MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES			FORM	: 11/26/2013 APPROVED . 0938-0391
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA. " IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING		ETED
	345172	11	B. WING	11/0	8/2013
NAME OF P	ROMDER OR SUPPLIER	11	A : [8	STREET ADDRESS, CITY, STATE, ZIP CODE	
TRIAD CA	RE AND REHABILITATION CENTER	; ;		167 NORTH ELM STREET HIGH POINT, NC. 27262	
(X4) ID PŘEFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DÉFICIENCY MUST BE PRÉCÉDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	11 12 12 12 12 12 12 12 12 12 12 12 12 1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (DEFICIENCY)	(X5) COMPLETION DATE
	2 (6 RM 25)				
F 221	Augustinia et al. 1919	-21	1 2		
1 221	Continued From page 11		F 221		1
	Narrative conclusion of root cause: "Due to	<i>M</i> .	1		
	resident decreased cognition and impaired	3			
	judgment he is at high risk for fells. As noted staff repositioned bolsters to ensure they are				
	position properly for comfort.				
	The resident's MDS information from 10/18/13 for				
	a significant change indicated he had severely	3.	1 1		
	impaired cognitive skills for daily decision making,	4			
	Resident #23 was totally dependent on staff for		1.9		
	locomotion and required extensive assistance for	4			
,	all other ADLs. He received G-tube feedings with	1			
	no food or fluid intake by mouth. There were no	5.5	1000		
	behaviors nor rejection of care noted on the MDS.			10年 使用的 经营业的	
	Coding of the MDS indicated that no restraints	, 1	4	[10] [46] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4	1
	were used for this resident.	1		\$ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	A review of Resident #23's 10/25/13 Care Plan	5-4			I
	revealed the use of physical restraints was not	14	1		j
	addressed. However, a Focus Area related to the resident's risk of falls included the following	eij ,	1.54	【2005 整件的基系建设的 Man]
	Interventions:	1	7.5	· · · · · · · · · · · · · · · · · · ·	
	-Bolsters to bed (Date Initiated 8/29/13; Revision)	4		在日曜時已經算算	1
	on 10/9/13)	341		1 等數學 說 轉輩時 以	1
	-Out of bed (OOB) in geri-chair (a specialized	Ü			
	wheeled recliner) when restless/agitated as	- 4			
	resident allows (Date Initiated 5/7/13, Revision on		- 1		1
	10/9/13)	1			
	Parameter mattress (no date noted)	5.4	1 1 1 1 1 1 1		1
	-Ensure bolsters in place; position appropriately			人名英格勒特特	1
	in bed; PT to evaluate (Dated 10/4/13)	ven		【四位教会》的 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1
	Resident #23's fell records indicated the resident	() ()	7 : 1		j
	had a fall without injury on 11/3/13 at 8:30 PM. The Fall investigation Records for 11/3/13				}
	provided details of the event as follows:	41:		*	
	What was resident doing at the time of the	11		1 100000000000000000000000000000000000	
	fall? "Attempting to Stand;	4		1、「原情報報報」	l
l	Interventions initiated immediately after fall: "		1.50		
1	Resident placed in the gerichair in open area; "	7			
	The Clinical Management Team determined that			[] · · · · · · · · · · · · · · · · · ·	
	the fall was related to: Cognition (designated by		,		ĺ

		D HUMAN SERVICES MEDICAID SERVICES	1				FORM): 11/26/2013 I APPROVED , 0938-0391
	of deficiencies . Correction	(X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING (X3) DATE SURVEY				
		345172	3 3	B. WING			11/0) 18/2013
NAME OF P	ROVIDER OR SUPPLIER	人名英格兰人姓氏格勒氏	1,	S	TREET ADDRESS, CITY, STATE, Z	IP CODE	<u> </u>	
TRIAD GA	RE AND REHABILITATIO	N CENTER			07 NORTH ELM STREET IIGH POINT, NG 27262			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD B TO THE APPROPRI		(XS) COMPLETION DATE
		, 医多类型 (多类型)		N	The second section of the second section of the second second second second second second second second second	JENCY)		
F 221	C		.1					[
Γ 42.1	Continued From page	12		F 221	[1] 核基层设施 [3]	N i i i		
	a checked box);	· · · · · · · · · · · · · · · · · · ·		1	1 美國一種湯	\$ 身形。		
	Recommendations to	prevent turner talls:		1 1 35 3				
	oral/mouth care. Gus	orlingenin applied for a	3					
	Summary of interview		- 11					
		er bolsters. Landed in the						
		o downstairs wants a drink.	- 1	1.12				ļ
		ort, no injury noted placed in	1					
		tation for monitoring,"	1.					
		n: Intrinsic (designated by a	h	,				
	checked box)							1
	Narrative conclusion	of root cause: # Impaired t	- 5	31	1			I
e .	judgement resident st		- 1	110000	I very single of the state of			
		ater. Mouth possibly dry. "	i- :	9.5				
, , , ,		nt's medical record revealed	1	- PU ;				
		ogress Note dated 11/3/13				t:		
		he following: "Continues to		th, ethyra				
	scoot to bottom of the	gerl-chair. Lifts bottom off	1.7	12	[] 建磷铁矿 经基础	4.光道:		
	the chair. Slides legs	to side of chair and twists	1		17 1、 翻题 1971年		j	
	body. Slides salf bac	k up when " caught."	+. 4			į.		1
		'Is getting up./	j.					ł
		when repositions him."		1 2 4 4 7	1 "原本,并提出			
		on 11/5/13 at 8:59 AM 3 3		944	1 《中国的一种发生			
,		o was asleep and lying still ious movements observed.				6		
		rameter mattress (a winged						
		s placed on each side of the				ľ		i
	bed.		, t					I
	1	ducted with Nurse #9 on	5 3					
		Nurse #9 was the staff	- []	1.3			1	1
	nurse assigned to Res	sident #23. The nurse 🗀 💠	3			E [1
	indicated Resident #2	3 used an air mattress and 🖰	i	,				İ
		s he " climbs out of bed, 🧺 🤄	(-) (-)		Land Hill			1
		he nurse stated the 🚎 🤴 🤻						
1		slows him down " and " !"	* 1			i.		j
		get out of bed if he wanted	* .			f. Ši	- [l
	;	sident #23 also had a bed	, į			§ 1	- 1	ļ
		staff when he was trying to	4.	1 1		ii f	İ	ļ
1	Aproper or upot		4.5	r ·		£ : .	i i	1

· 人名斯 经原始编码。

		ID HUMAN SERVICES MEDICAID SERVICES	4			NTED: 11/26/2013 ORM APPROVED 3 NO. 0938-0391
	DF DEFICIENCIES . CORRECTION .	(X1) PROVIDER/SUPPLIER/SULA IDENTIFICATION NUMBER:	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	A BUILDING		DATE SURVEY COMPLETED
		345172	1	B. WING	<u>いっている時間は、「日本</u> 事業員」を	11/08/2013
NAME OF A	ROVIDER OR SUPPLIER	一次 1992 國際基備影響	Ş	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
TRIAD CA	RE AND REHABILITATIO	ON CENTER	11. 11.	4	07 NORTH ELM STREET HIGH POINT, NC 27262	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAY OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			The state of the s	
F 221	Continued From page	13	4. 4.	F 221.		
	A follow-up interview	was conducted with Nurse	4			()
		PM regarding the type of	1		10 对视图的 隐藏疆籍部分]]
		t #23. Nurse #9 was the	3			
		o the resident's hall. The	(4) (4)			
	nurse demonstrated l	now the bolsters were put 3		}		
	into place on the bed	and stated that without the	- 1		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	
	bolsters, the resident	was climbing out of bed.	ket str			
		ing the bolsters in place,			★ 17 数16 数16 数16 数16 数16 数16 数16 数16 数16 数16	
-		ast slows him down" so the		specify of		
		If if he was trying to climb 📳	- 190			
		also stated the resident did 🥼	. 1	4	· 医福尔氏的 输送器 1	
		Noon to 4 PM each day	i			
		was turned off so that he		1 2 2 2	1 一点 最后的 医克塞曼特别	
		en asked, Nurse #9 🏥 💮		1		
	indicated that Reside	nt #23 usually dion't try to 🕬	1 (4) (4)		The first of the state of the s	
		air. However, the nurse . 3	1			,
		an alarm in place on the 🖑 🥛	* }	3.00		
		nt #23 had tried to get out	i di	7.5 7.1	10 多数程序设置 14 1	
	of the chair in the pas		- 3		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	
		erved to be awake and		9		
		s movements in the $ e \otimes 4 \phi$	\mathcal{F}	* .		1
		on 11/7/13 at 2;15 PM,	•	16	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	
		ducted with Nurse #8 on 🖖	1		10000000000000000000000000000000000000	
		garding the resident's bedi				
		at Resident #23 had **				
		Upon further inquiry about	211	7 (2)		
	me purpose of the po	Isters, Nurse #8 stated it	- (1		1、《觀片機構製造》	
	him.	wn " so they could get to			[1] (1) [2] [2] [2] [2] [2] [2] [2] [2] [2] [2]	
	•	ducted with Nurse #11 on	14:			
		garding the general use of	: "		1 1 1 2 2 4 2 2 1 2 2 2 2 2 2 2 2 2 2 2	
,		beds. Upon inquiry, Nurse	1			1
	;	me of the residents had	: 1			
į		ers in place because, *** ···		'	1 / 2 製造物質的	
		get out of bed. " She	1		医异激带 电键编译器	
		de rails could not be used,3	E. 4			
		e may be used and that, " «		1 1 1		
		n from falling. "i	ď.	95.5		
	An intentiou uise con			7.6 %	【 · · · · · · · · · · · · · · · · · · ·	

	•	AD HOMAN SERVICES		. 11		FÓRM APPROVE
CENTER	RS FOR MEDICARE &	MEDICAID SERVICES	::: 		en en er syn i vitaliste i en e	OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA: AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER:		LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		1 人名英格兰德		·	San A Special Control of the State of the St	c
		345172	B. Wil	∜G		1
NAME OF P	ROVIDER OR SUPPLIER	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	<i>0</i>		STREET ADDRESS, CITY, STATE, ZIP CODE	11/08/2013
	***************************************	[1] 计复数逻辑重量摄影器		41 A	表现的变形 化二甲基甲酚酯 人名英格兰	
TRIAD CA	RE AND REHABILITATION	ON CENTER		5.4	707 NORTH ELM STREET HIGH POINT, NC 27262	
(X4) 1D		ATEMENT OF DEFICIENCIES		מו	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL () LECTION () A PROPERTY OF THE PRO		EFIX AG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROX	
17.0			'		DEFICIENCY	NAI G
·····		to the state of th	5 1 -			
F 221	Castleyand France and	1. 1000年 1965年 1968年 196				′,
L 573	Continued From page			F 221		
	Assistant (NA) #1 on		5.			
		assistant noted she had not	264 j		本科學學科學 医多种囊腺 医二二	
		t#23 very much in the past,	Ų v		T. 可以以下,数据基础。	
		lent did have one legion top.	3	100		
	of the boister during t	he night and she had to		19	I American Marketine	
	reposition him.	A STATE OF THE STA	i.	12	4 、 「類質」「効果素として、	
	An interview was con	ducted with Nurse #2 on	3	p. 18	1 / 現代與自身建議的一个	
	11/8/13 at 6:48 AM,	The nurse reported Resident				
	#23 could work hims	elf out of the bed but noted <	30			
	he could not do so sa	fely because he falls, She?	3		【一类操作的确定精囊的 》。	
		had an air mattress in place		100		
•	and the bolsters prov	ided an extra height on the		. · ' . · ·		
·		from falling. Nurse #2	# J			
100		e bolsters in place he could	24.9			
		urse indicated that she	\$ \$ 6 00		★ 10 14 14 14 14 14 14 14 14 14 14 14 14 14	
		the resident get his feet over		3		
	the bolsters when the	y were in place. However,		gia		
		Resident #23 has pushed	4		The state of the design of the second	
		here staff had to reposition	6			
		his feet. When asked if the	i -	A_{ab}		
		the geri-chair, Nurse #2 4 3	sii ,		【如:魏·杨泽·阿黎斯】【[[1] 15 15 15 15 15 15 15 15 15 15 15 15 15	
		feat for him to get out of	5	4000	化二基磺胺四基酚基磺酸亚亚亚	
	there I wouldn't not i	past him. " She reported		3		
34			9	AL.	1 人名西拉拉马克 動物	
		to have a broda chair (a				
		ts to different positions) and	¥ "			
		to get out of it. The nurse	.	÷	▲ 一般 体品的 医二羟基苯基	1
		as changed to the gen-chair		- 6	】 「大海中田」「13 th (14 / 17)	
		I physical state. When	`. ·			
		sident's inability to get out	E. 1	. *	1 2 3 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	
	or the geri-chair was	due to his physical decline or		.5		
İ	the change in chairs,	Nurse #2 stated, "I think it!	N .			
		rence in the chair."	5 S		1 医雌冠氏物腺囊腺炎	
İ		on 11/8/13 at 6:58AM		, Toronto Tage	【大人生發展 人名马基基图》	
		3 was asleep and lying still			1 多数原始的对抗	
		with the bolsters in place.			1 人名特别特别	
,		ducted with NA #2'on Figure 1			1、增加、增加、数量和分分。	
					1、16 经销售额	
		ss and bolsters were used		1	In a last to the state of the s	
	for Resident #23 's b	ed. the CNA stated that the	í			1

		D HOWAIN SERVICES		and the second			APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	11.	, ,	The fire property and the	OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	;	(1) · · · · · · · · · · · · · · · · · · ·	1	5			c
	, , di ()	345172		B. WING			08/2013
NAME OF P	ROVIDER OR SUPPLIER	1 5000 E V 1 1 1 1 4 1 4 1 4 1 5	-26 A	S	TREET ADDRESS, CITY, STATE, ZIP CODE	'	00.0010
				一 一 一 一 一 一 一 一 一	OF NORTH ELM STREET	-	
TRIAD CA	RE AND REHABILITATIO	ON CENTER	(d) L	7.32	IGH POINT, NC 27262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUSY BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID' PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS REFERENCED TO THE APPROP	HE	(X5) GOMPLETION BATE
			17		DEFIGIENCY		
	•	11 3 3 3 3 3 3 3 3 3	17.	ara yan da k	1. () · · · · · · · · · · · · · · · · · ·		
F 221	Continued From page	16	1	F 221	1000000000000000000000000000000000000		
			3				
		the bed and from falling,"s			[1] 图 [1] [1] [2] [2] [2] [2] [2] [2] [2] [2] [2] [2		
		sident could get out of bed	- E		中国 使成为自然的 法基础基础的 "		
	on his own, the CNA		1		[1] [2] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4		
		served to be sitting with no		1.77.77	· 中華 新學科 一种黄色 (黄素) (1)		1
		while resting in the gen-chair	•				
	in his room on 11/8/1						
÷		ducted with the Director of		** * * *			
		egional Director Consultant					
		A. During this interview, the		1.			
		n't use an assessment for .	1				
		s not a restraint, "Upon	Į.				{
		ng the reason for the use of			○ 所以 2.5 性 2.5 全身では、		1
		l's bed, the Regional	2 d A	1 11 11	[[[[[]]]]] [[[]] [[]] [[]] [[]] [[]] [1
		idicated it was because the		1.50			
		out of bed. She stated that		1 Standalors	ि स्तरि विविधाल एक हैं इन्हें हैं। है है है		
		slows them down."					
		ducted with Occupational	2,		1000 新洲 数量清点		
* * 7 - 3		/1 on 11/8/13 at 11:53 AM.		** - **			
		is familiar with Resident #23	3		人名 佛 经通过基础		
		stantly trying to get out of		4	[三·建国][[[[[]]]][[[]]][[[]]][[[]]][[]][[]][[
		dicated that she believed he.		1 10 10			
		of the broda chair so he was					
	wasn't safe for him ar	ir. She stated,," It just		1	17.5.445. 罗斯克斯蘭的特殊		
	3						
		geri-chair reclined he is 🔆 When asked if Resident #23	di j				
		structions, OTA#1 indicated		1			
		k so. When asked if he	1.1				}
			2)				†
		v to get around the bolsters		St. 6-12.7]
				* :			
		ducted with the Director of tegional Director Consultant			10. 建新面包挂针2000		
		legional Director Consultant	1				[
		d Regional Director 33	L.		1 1 深处的 经基础提出 1 1		
		the bed alarm was put on	. ;	3			
	the resident 's bed to		v				
		ening. They also stated that	* (1)				
		rameter bed was to alort him	111		1000年 1988年 - 大大大大大		1
			γ_{P}				
	(une resident) and the	bed bolsters were also	1.	1	<u> </u>		1

	MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES			FORM	11/26/2013 APPROVED 0938-0391
STATEMENT (OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION (X3) DATE S COMPL	BURVEY EYED
	345172	2°	B. WNG	C 11/0	8/2013
NAME OF P	ROVIDER OR SUPPLIER	2 1	45 45	STREET ADDRESS, CITY, STATE, ZIP CODE	
TRIAD CA	RE AND REHABILITATION CENTER	, 1		OT NORTH ELM STREET HIGH POINT, NC 27252	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES () (EACH DEFICIENCY MUST BE PRECEDED BY FULL (REGULAYORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROMOER'S PLAN OF CORRECTION (PACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 221	Continued From page 16	- 19	€ F 221		
	used to alert him of the edge of the bad. They			1、10、1000年1月1日	
	indicated that the resident was not cognitively	-iς,		[6] (1) · [6] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4	
	aware of what he was doing.	100			
	An interview was conducted with Nurse #17 on	- 45		[1] [2] [2] [2] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4	
	11/8/13 at 2:45 PM. Nurse #17 shared the responsibility for completing the MDS and share.				ļ
	indicated the MDS nurses were responsible for		1		
	completing Section P (Restraints) of the MDS				
	assessment. When asked where this information			200	
	came from, the nurse indicated that when a	- 1			
	device was used as a restraint, it would be	1			
	assessed as a restraint on a form under the "	7		1 4 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	
	Assessment tab " in the resident's medical in the	;		1	
	record. In addition, there would be an MD order.	•	N 100	[1] 12 10 13 12 13 13 14 14 14 15 15 15 15 15 15 15 15 15 15 15 15 15	
	which would usually explain the reason for the	÷ ;		10 全等的投资重整的	
	restraint, and it would also be noted on the care	1		1 3 4 6 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	
	plan when it was put into place. Nurse #17, 🎠 😤	d		1 化油油 法证债债	
	reported that if a device was assessed to be a	71	5 374 2 514	· · · · · · · · · · · · · · · · · · ·	
	restraint, it would be coded as such on the MDS	·			
	in Section P.				
	A follow-up interview was conducted with Nurse	1	** ** **		
	#17 on 11/8/13 at 4:00 PM. During this interview, she confirmed that the MDS nurse was not			1 元化。""别特别说。"	
	responsible for determining whether or not a 3 1 11		**	1 人類的主義計劃的 一十	
	device was considered to be a restraint and that it		11	Transfer of the American A	
	was up to the nurse managers to do that.	ķ.			
į	An interview was conducted with Nurse #15 on it				
	11/8/13 at 4:15 PM. Upon Inquiry, Nurse #15 (🛊 🖰	211			
	stated the nurse managers for each unit were	- 6	1 b a	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	responsible for completing a restraint assessment		•		
	form for each resident who had a restraint. She	3		1	
	indicated the Interdisciplinary Team (IDT)				
	determined what was considered a restraint and				
	what was not through group discussion,	1.5		1 3 40 4 4 4 6 7 7 1	
	An interview was conducted with the DON on 1 11.	1 :			
ļ	11/8/13 et 4:34 PM. Upon inquiry, the DON stated that if a resident was having any kind of falls and	£ . Y			
	there was a need for a restraint, the issue would	• (
	be discussed in an IDT meeting, a care meeting,				

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES		SE		PRINTED: 11/26/2 FORM APPRO' OMB NO. 0938-0	VED
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345172		B. WING		C 11/08/2013	
NAME OF P	ROMDER OR SUPPLIER	1957 地北海塘港一	- 43		STREET ADDRESS, CITY, STATE, ZIP CODE		
TRIAD CA	RE AND REHABILITATIO	ON CENTER			707 NORTH ELM STREET HIGH POINT, NG 27262		
(X4) ID , PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	11 A	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	BE COMPLET	
			33	1	DEFICIENCY		
			1.1				
F 221	Continued From page	17	, <u>l</u> .	F 22	21		
	and/or stand up meet	ing. The meeting would	- 1	1			
	involve a verbal asset	ssment and discussion					
	among the teám mem		- 1	10000000			
	assessment tool woul	d be produced during this 🦠	ŧ.; '		· 【中国新州东西、新疆田中、中		
	meeting. The DON in	idicated that if a resident	- 1		1. 1 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.		
		ve a restraint in place, a	- 1				
		ssment would be completed	3)				
	and placed in the resi						
		admitted to the facility on 👢	T_{i}				
		ive diagnoses included					
		history of falls, hypertension,					
		diabetes. The annual	. 1	1 1			
		IDS) dated 8/9/13, indicated	- 1	100			
		uired total to extensive	7 .				
		h transfers and 1 person					
		ily. The MDS did not code					
		ambulation or falls during		* * * * * * * * * * * * * * * * * * * *		- 1	
	the assessment perio		: 1.				
	The about the party	វីម៉ែង ម៉ា ខេត្ត ខេត្ត និង	. 1	1 1	· 【 题 糖粉生 类为特美的。		
	Review of the care of	an revision dated 9/9/13			 [1] F. S. S. S. S. S. S. S. S. S. S. S. S. S.		
		related to history of seizure,	11.1				
		s and impaired balance.	1				
		significant injury related to:					
	fall. The approaches i	ncluded the use of the	3.1 3.3	177 miles 178			
4.4	parameter mattress(1	0/20/2009) and wedge	4.4		1. [1] 在 1. [1] [1] [1] [1] [1] [1] [1] [1] [1] [1]	1	
	bolster, used hoyer lif	l for transfers, 2 person 🔏 🦠			(1) 《新疆》诗诗播》	-	
	assist with transfers, v	wedge bolsters indicated	- 1	., .,			
		rred assessed for injury			"什么不明心,你就看着我看什么。"		1
	notify physician and fo	ollow orders, bed alarm	: 1			ļ	- 1
	check functioning plac	cement every shift	r		· [16] 紫蘋(金属群)。		ļ
	Daving of S. 12.		1	1	一	1	
	Keview of physician o	rders dated 10/17/13 and] .	The house of the second		
		I there were no concerns	- 1				-
		the need for bed bolster or, was no physician order or					- 1
		use of the parameter.	2.7				l
	mattress or bed bolste		÷ :				
						4	
			5.7				

		MEDICAID SERVICES	13.			FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	7	(X2) MULTIPLE	CONSTRUCTION 1	(X3) DATE SURVEY
AND PLAN OF	CORRECTION .	IDENTIFICATION NUMBER:		A. BUILDING		COMPLETED
		★ 13 (1) 自身 (注)	3			C
		345172		B, WNG		11/08/2013
NAME OF P	ROVIDER OR SUPPLIER		.,		STREET ADDRESS, CITY, STATE, ZIP CODE	
TALLE 6	The Chille Maria man property		,	· • • • • • • • • • • • • • • • • • • •	07 NORTH ELM STREET	
TRIAD GA	RE AND REHABILITATI	ON GENTER	**		IIGH POINT, NC 27282	
(X4) ID		TATEMENT OF DEFICIENCIES 👯 👍	-	ID" "	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		CY MUST BE PRECEDED BY FULL (1997).	15.5	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
ir.c.			3	,,,,,	DEFICIENCY)	
		. 4 - 5 - 6 - 6 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7	35			
F 221	Continued From pag	A 49		E-004	To the second second	
	1			F 221		
		progress noted dated	7.17	1.3	· 连翻 正线 结裂的 500	
		ne visit was associated with	1		中,自己经验收入证据重量的全国。	
		and chronic disease. No 📑 🗀	15			
		safety concerns related to her	6		[17] 中国的 100 全国基础的 174	
	getting out of bed.	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	- Spire			
			- Si - 1	4	1 李维/ 印 / 接着的 / / / /	
		g notes from 6/18/13 to				
		o indication or concern with	1			
		o get out of bad or stand	.i.			
		notes revealed behavior	1 () 24.	•		
		l as verbal abuse, yelling, 1			1 人名英格兰 医多种	•
		ing clothing, self inflicted		16 44 7	透磁压电镀锅2000000	1
		and medications were used	41			
		There were no concerns				
		. Nurse#15 reviewed the	- 1			
		ged and confirmed the notes	e4.			
		dress and behaviors where		1000	[17] "艾····································	
		pted to get out of bed or			★大學 (鐵路 200m年 基 基) (100mm)	
		over side rails or bed bolster	il.			
**	· ·	he primary use was for	1			ł
	safety.		1	4 1		Ī
	During on aboardalia	and de legal at 2 and 1 and 1	17.			İ
		on on 11/8/13 at 3:30PM, half naked with top portion of	11	164	1 李璐 电影特别统合	
		th the door open, Resident;			The state of the control of the state of the	
		vanted to get out bed and go	ist			
	to the closet Pacida	nt had a parameter bed and		1		
		in place and half side rails	4			
		nfused and holding onto side	f		1 文理经验 建硫磺基铂	
		op of the bed bolster and side				
	rails,	A or me ned unister diff side	4			
	INDV		<u>;</u> :			1
	Dunna an Interview s	vith Nurse#12, on 11/8/13 at		1		
		at resident did not walk and	: 1		1 "金宝"。 名 经建筑企业	
		nly throws legs to the side of	11	0		
		She was unaware of the	.i.			
		falls in the past few years.	í. ·			
		edirected to put legs back in	1	1	1	
	had without alternat		61			

	MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES				PRINTED: 11/26/2013 FORM APPROVED IMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 345172		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 0	X3) DATE SURVEY COMPLETED C 11/08/2013
	ROVIDER OR SUPPLIER RE AND REHABILITATION CENTER		y	STREET ADDRESS, CITY, STATE, ZIP CODE 107 NORTH ELM STREET HIGH POINT, NC 27262	
(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)	(XS) COMPLETION DATE
F 221	Continued From page 19		F 221		
2 -4 2 - 2 - 2	During an interview on 11/8/13 at 3:45PM, Nurse#15 indicated that Resident#41 had not had any falls in several years and the use of the				
	parameter bed and bed bolster was a reminder for Resident #41 not to get out of bed and safety. She indicated that there was no assessment to	11			
	determine the need for the use of the parameter bed with bed bolster since the resident was able to throw her legs over a regular bed without an attempt to stand. Nurse#15 added that staff				
	would redirect the resident to put her legs back in bed and no assessment was done for either since it was not considered a restraint.	7	1	· · · · · · · · · · · · · · · · · · ·	
	During an interview on 11/8/13 et 4:05PM, the nurse consultant indicated that a new program				
	would be implemented to assess for the use or need for bed bolster/parameter beds in the same format as a restraint would be on the newly.				
F 244	devised form for the facility and staff would be in- in-serviced on the accuracy of assessments for devices, 483.15(c)(6) LISTEN/ACT ON GROUP		F 244		
8S=D	GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility	11	F 244	F244 1. Residents #89, #221, #132, #137, #	! 7
	must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		were interviewed by the Dietitian/ Food Service Director (FSD on 11/29/13 concerning the food)
	operational decisions affecting resident care and life in the facility.			preferences, food palatability and foot temperatures.	od
	This REQUIREMENT is not met as evidenced by:				
	Based on resident and staff Interviews, and	τ1			

DEPART	MENT OF HEALTH AND HUMAN SERVICES			PRINTED: 11/26/2013 FORM APPROVED
CENTER	S FOR MEDICARE & MEDICAID SERVICES	sg transf	The state of the s	OMB NO. 0938-0391
	OF DEFICIENCIES (X1) PROVIDENSUPPLIENCIA IDENTIFICATION NUMBER:	(X2) MULTIPU A. BÜILDING	e construction	(X3) DATE SURVEY COMPLETED C
	345172	B.WING		11/08/2013
NAME OF P	ROVIDER OR SUPPLIER	en i errei s	STREET ADDRESS, CITY, STATE, ZIP CODE	
TRIAD CA	RE AND REHABILITATION CENTER		707 NORTH ELM STREET HIGH POINT, NG 27262	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL) REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLÉTION DATE
F 244	Continued From page 20	F 244	2. Residents have the potential to h	be .
	review of resident council minutes, the facility		affected by this practice were	}
	failed to resolve ongoing group grievences for 5		Identified by conducting random	
	of 5 sample residents (Resident #89, 221, 132,	関連の	interviews of residents	,
	7, and 137) with concerns regarding cold food $\frac{\pi}{2}$	7.65.47.1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	_
	The findings included:		on 12/02/13 by Dietitian concernin	- 1
٠ .			palatability of food and timeliness of	
	The facility identified the residents as alert and		tray delivery. An additional food ca	1 1
	oriented.		is being utilized on two halls to redu	uce
	During an interview on 11/5/13 at 10:00 AM,	,	the amount of time the trays are	
}	Decident # 90 Indicated funds and gungraiges not		waiting to be delivered which will	
	good and there were concerns with the		ensure that food is at proper	
	preparation of the meal and the meal choices.	A 98. 4	temperature, Plate warmer was	
	· · · · · · · · · · · · · · · · · · ·			
	During an interview on 11/5/13 at 11:13 AM, 📑	,	serviced by the Maintenance Direct	or
	Resident #221 indicated all the meals were		on 12/02/13& is maintaining the	
	served cold and she had to go reheat the meals		correct temperature.	
	herself, Resident #221 added that this concern had been brought to the attention of several of]
Ì	the staff with no change.		3. Re-educated Nursing staff on	
•			12/03/13 by Staff Development	
	During an interview conducted on 11/5/13 at		Coordinator (SDC) concerning timel	,
	11:56 AM, Resident #132 indicated that he had		delivery of meal trays,	'
	trouble eating the food for all three meals:			
	Resident #132 stated he eats in his room and the trays typically sat out in the hallway for some time	Market by	asking resident if their food is warm	
	before being brought in and the food was typically		enough and heating food if needed.	
÷	cold.			/13
, 1	· 一直大量的過程的		by the FSD/Dietitian concerning	
	During an interview on 11/6/13 at 9:00 AM		ensuring proper food temperatures	
1	Resident #7 indicated as a resident council		prior to meal service.	
	member there had been an ongoing concern regarding the food being late and cold.		1 计一段特色数据建筑中心	
			· · · · · · · · · · · · · · · · · · ·	
	During a follow-up interview on 11/7/13 at		· 美物,这个种种 种 教育的	
	5:35PM, Resident #89 indicated that all the food	4 6 7	· 及一般的一种分类的	
	comes out cold and that the trays sat on the hall			
	for 30 minutes or more. He indicated that he had		】 - 2 \$200 See 2 6 5 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	

	MENT OF REALITIAN						M APPROVED
CENTER	S FOR MEDICARE &	VIEDICAID SERVICES		n în în se	The state of the s	7	<u>), 0938-0391</u>
	of déficiencies Foorrection	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	ECONSTRUCTION		SURVEY PLETED
	• . 1				化二氯甲酰酚 经销售管理	1	Ċ
		345172	á	B. WING		1	- /08/2013
NAME OF P	ROVIDER OR SUPPLIER	307 0 0 0 0 0 0	135.0	<u> </u>	YREET ADDRESS, CITY, STATE, ZIP CODE	1 11	0072010
			7		07 NORTH ELM STREET		
TRIAD CA	RE AND REHABILITATIO	N CENTER	Ġ		HIGH POINT, NC 27262		
(X4) ID		TEMENT OF DEFICIENCIES	1.1	10	PROVIDER'S PLAN OF CORRECTION		(%5)
PREFIX		MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		GOMPLETION DATE
TAG	REGODATOR! ON C	oo logarii ilito ili okwanoliy	25	TAG	DEFICIENCY	AIE.	
		L s Service	11.14	<u> </u>	1 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	 	·
			1		19 時期的日本學業學的「在漢		
F 244	Continued From page	21 / 27 / 2 2 2 2 2 2 2 2 2 2	244 24	F 244	4. Dietitian and FSD will conduct fo	od	
	reported this concern	on several different	1		palatability interviews weekly time	s 4	•
	occasions and no one	has time to reheat the	4		1		
	food.		15 5	1 1	weeks then monthly times 2 month	1\$	
	• ,		3		and report the findings to the Pl		
	During an interview or	11/7/13 at 5:28PM,			committee monthly times 3 month	s to	
		ed that his lunch was cold	Ł.,				
	when it arrived at 1:30	PM. He indicated that the	$\gamma_{\rm h}$		ensure compliance and consistency		
		about 30 minutes and very	242		Menu Meetings will be held weekly	,	
		at they did not have time to	1	Market	times 4 weeks and then monthly.		
		asked. He indicated the	."		Temperature test trays to be		
		n the meal was delivered			4 2 9		·
		hall another 30 to 40	3		completed 3 times per week times	one	
		the room. He indicated	ji.		month then weekly times one mon	th.	
		d to nursing and dietician.			then monthly.	,	12/05/13
		also run out of food as well	11		men monuny,		
		get an alternate. He also	1		1000年100日 1000日 1000日 1000日 1000日 1000日 1000日 1000日 1000日 10		
		his cold beverage would.	í.				
	come hot or not at all.		.,	1 . J. S			
		ed in September regarding	114	1 1 1 1 1			
		and late arrivals of meals,		1.0			
	but nothing was chang				医内侧 鐵裝品 医紫色囊胚 计图		
	THE TOTAL STATE OF THE STATE OF						
;	During an interview on	11/7/13 at 6:10PM; the			[1] [1] [1] [1] [2] [2] [2] [2] [2] [2] [2] [2] [2] [2]
		d that she was aware of		1 1 1 1			
		with meals temperatures.	27: N	1. 19	L. 何望。饮料\$P\$\$P\$		
		be the DM and RD	11	9 4	· 连腰 研制 特勒		
1		with individual residents	7:		医大小线 网络克罗森德国 电流流		
		il and resolved them to					
- 1		ith the new changes.	-	1. 1.			
	reament detratection to	int the new changes.			1、研究的一种教育 美国		
	During an interview on	11/8/13 at 8:23AM, the	# 1		· · · · · · · · · · · · · · · · · · ·		
	activity director(AD) in		, ,				
1		ig the residents with the	7				
		ig the residents with the igs. The AD added that the		, :	医牙部腺 新錢豐原區		ļ
}			1.1				ļ
		been reviewed monthly	4				
		ntion of the department		,			
		ng meatings. The residents	Ġ.		医乙二磺胺胺 经收益净额 经经营]	
		res related to cold food			· 中国生活。1886年18月1日		
	and late meal arrivals.	sne added that the 🦂 👙	<u>;</u>):		· · · · · · · · · · · · · · · · · · ·		

	MENT OF HEALTH AND HUMAN SERVICES	11			PRINTED: 11/26/2013 FORM APPROVED DMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER:	10 g	(X2) MULTIPL A. BUILDING	5 CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
	345172	ř.	B. WING		11/08/2013
	ROVIDER OR SUPPLIER	4451 7.5	<u>, </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
TRIAD GA	RE AND REHABILITATION GENTER	3.Car	(4) (2) ← 2/2 = 5	707 NORTH ELM STREET HIGH POINT, NC 27262	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	2	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIAT DEFICIENCY)	
		3			
F 244	Continued From page 22		F 244		
	concerns had not been resolved to resident satisfaction.				
	Review of the resident council months dated 5/30/13, 6/27/13, 7/25/13, 8/29/13, 9/26/13 and 10/24/13, revealed continued concerns regarding				
	food temperatures, late meal arrivals, not being	11		10章 機能に対するよう。 東京教育を行っている。 10章 機能に対する。 10章 機能は対するという。	
	offered snacks or alternate meals, lack of posting	3			
	of menus and running out of condiments. The sidents concerns had not been resolved to the residents.				
	satisfaction.				
F 272	483,20(b)(1) COMPREHENSIVE	**	F 272	F272	
\$5≂D	ASSESSMENTS	81 31		1. 法建筑证据 往 数 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	The facility must conduct initially and periodically			1. Residents #1, #23, #41, and #171	
ļ	a comprehensive, accurate, standardized	4		had restraint/device evaluations	
•	reproducible assessment of each resident's		$r = \epsilon$	completed on 12/2/2013. Each	
	functional capacity.	7		resident's care plan and RAI, if	
	A facility must make a comprehensive	4,		needed, was update to reflect the	
	assessment of a resident's needs, using the	3		resident's current condition and any	
	resident assessment instrument (RAI) specified			medical device/restraint in use.	
` .	by the State. The assessment must include at	* 1	198484 4	· · · · · · · · · · · · · · · · · · ·	
	teast the following:	i .		2. A device evaluation will be	
	Identification and demographic information;	: 2	, ,	completed on all facility residents by	.
	Customary routine; Cognitive patterns;	\ <u>}</u> .		Their RAI and plan of care will be	
	Communication;	1.0		updated to reflect the outcome of th	
	Vision;	•		device evaluation and their current	·
	Mood and behavior patterns;			事 ニカー・ライン しょうけいきん ぎょん	
	Psychosocial well-being;		ji	status. The device evaluation will be	
	Physical functioning and structural problems;	vi.		completed on new admissions, with	
	Continence; Disease diagnosis and health conditions;		Markini.	quarterly, annual and change of	
	Dental and nutritional status;			condition assessments. The resident	's
	Skin conditions;	4	i sa sa 🙀	RAI and care plan will be updated	
	Activity pursuit:		was in	upon completion of the device	
	Medications;			evaluation.	
- 1				೬ ರಾಜ್ಯಾಧ್ಯಾಗರಾಗ ಕು. ಕಿ.ಎ. ಕ್ರಿಕ್ಕಿಸಿಗು	1 1

	MENT OF HEALTH AN					FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	7	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345172		B. WING		1	C /08/2013
NAME OF P	ROVIDER OR SUPPLIER		; i,		STREET ADDRESS, CITY, STATE, ZIP CODE		
TRIAD CA	RE AND REHABILITATIO	N CENTER	持 4		HIGH POINT, NC 27262		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	in the second	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REPERBICED TO THE APPROPE DEFICIENCY)	BE	(XS) GOMPLETION DATE
·		1.1.4. (1) ELECTION	144	1.77	· · · · · · · · · · · · · · · · · · ·		
F 272	Continued From page	23	342 1	F 272	3. The Director of Nursing/designs	e	
	Special treatments an	o procedures;		م ماريو.	will audit newly admitted resident]
	Discharge potential;	一点分子人 化克里斯基抗	4 -				
		mary information regarding	17		charts within 72 hours to ensure t		
		nent performed on the care			device evaluation has been compl		1
	areas triggered by the Data Set (MDS); and	completion of the Minimum			and care plan has been updated.		
		licipation in assessment.	1.		Clinical Reimbursement Coordinat	Òľ	
	boominomader of part	10 July 10 Jul			will audit the resident's charts on) ·	
	·	10 miles 140 miles 140 miles 140 miles 140 miles 140 miles 140 miles 140 miles 140 miles 140 miles 140 miles 1	1.		quarterly and annual basis to ensu	re	
			1		the RAI and plan of care are	•	
			3		comprehensive and accurate.		
	1		4,		comprehensive and accurate.		1
			14	16 2	4. Residents who experience falls	ar	
1	This REQUIREMENT	is not met as evidenced				11	
	by:	555 L.C.	1		other changes of condition will be		[]
		is, staff interviews, and			discussed and assessed daily in the]
		lity failed to assess for the	4		morning standup meeting by the	TC	
ĺ		before utilizing perimeter		1 3 3 1 1	team Care plan interventions will	be .	
	residents reviewed for	olsters for 4 of 4 sampled"	1		updated and implemented		1 1
	(Resident # 1, #23, #4		(4) (4)		immediately as needed. A weekly		1
	#171).			4 10 1	audit will be completed by the		
			*		Director of Nurses to ensure reside	nto.]
		admitted to the facility on		i i Wille	■ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1116	
	7/17/09. The cumulative	e diagnoses included istory of falls, hypertension,			who have had falls or changes in		
	seizure disorder and d		21		condition have had a fall assessme] [
j		S) dated 8/9/13, indicated			device evaluation, RAI, if needed, a	nd	
1		ired total to extensive 🖟 🎨		Nr.	updated plan of care completed ar	ರ -	
	assistance with activiti		1		signed off by the IDT team. Results	of	
ł		transfers and 1 person	3		the audit will be reported during th	e	
		y. The MDS did not code	::	,	monthly PI meeting. Weekly audit		
	the assessment period	ambulation or falls during	3,	**	will be conducted for 8 weeks then		
		e consequence of restraint,				₽I≺	12/06/13
		the restraint, any other			weekly for 4 weeks?		-11, 04, 13
		s or determine what		4 / 1			
	medical symptom the p	parameter mattress/bed					

		ID HUMAN SERVICES MEDICAID SERVICES		*		FORM APPROVED MB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	13) 24) 15)	(X2) MULTIPLE	7,000	X3) DATE SURVEY COMPLETED
		345172	登り景	B. WING		C 11/08/2013
NAME OF PI	ROVIDER OR SUPPLIER		1	141	TREET ADDRESS, CITY, STATE, ZIP CODE	
TRIAD CA	RE AND REHABILITATIO	ON CENTER		· · · · · · · · · · · · · · · · · · ·	67 NORTH ELM STREET HIGH POINT, NC 27262	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1 11 11 11	ID PREFIX TAG	PROMDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E DATE (X5)
			7.3			
F 272	Continued From page	24	55	F 272		
	bolsters was treating	because the facility thought	- 1	1000	图 中国最高级的基础上的	
-	the mattress was an o				b 《 數量符 数	
		L. C. C. C. C. C. C. C. C. C. C. C. C. C.	11	4		
	Review of the care pl	an revision dated 9/9/13, 🔫	4,		[17] [18] [18] [18] [18] [18] [18] [18] [18	
	identified risk for falls	related to history of seizure,			Adams (Addition to	
	poor safety awarenes	s and impaired balance.				
		significant injury related to:			小袋/用沙鞋建防护。	
		included the use of the			The state of the s	
		0/20/2009) and wedge	. î	1		***
		t for transfers, 2 person.	11	M		
		wedge bolstere indicated	- :-	1	【15 1字 Agus 1430 Agus 12 13 13 13 13 13 13 13 13 13 13 13 13 13	
- 41.4		rred assessed for injury	4.1 241		4. 网络阿拉拉有第2	
The		ollow orders, bed alarm				
1 1 ±	cuecy renegoning pla	Cement every stille		1 1		į
	Review of physician A	orders dated 10/17/13 and				
		I there were no concerns	1,1			
		the need for bed bolster or,	- 1	4 3 3		
		was no physician order or				1
		s use of the parameter				
	mattress or bed bolst					
			7.	7.4	1. 《新花》 李文诗 秦林 2000	
	An interview was con	ducted with the Director of	•	1.3	上 在一个建筑过度企业整确设计划	
		tegional Director Consultant	•			ļ
		 During this interview, the 		1 4 Sec.		
		on't use an assessment for ;	1		【4.5.数 45.数数数分	
		s not a restraint, ". Upon				
		ing the reason for the use of .	1		[1] 自動物 医肾髓囊肿 化多二	
		's bed, the Regional				
		ndicated it was because the bout of bed. She stated that;	- 1		[1] [2] [2] [2] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4	
	use of the bolsters, "				【《传》《宋·苏绍《 【 】	
	nee or me photess.	orous mem down.			1. 1等數計算器額由 2	.
	An interview was con	ducted with Nurse #17 on			D. C. C. C. C. C. C. C. C. C. C. C. C. C.	
	11/8/13 at 2:45 PM. I		1			
	l e	pleting the MDS and she	1			}
•	•	rses were responsible for				
		(Restraints) of the MDS	1)			
	assessment, When a	isked where this information	1		F · 理解: 15月 数针 2 1 2 2	1

		MEDICAID SERVICES					MAPPROVED 0. 0938-0391
	OF DEFICIÉNCIES	(X1) PROVIDER/SUPPLIER/CLIA	-	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	1	A BUILDING			LETED
	·		12.		Santa da la contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata La contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la co		C
-14 4 , 4 , 4 , 1 , 1 , 1 , 1 , 1 , 1 , 1	·	345172	ě,	B. WNG		11/	08/2013
NAME OF P	ROVIDER OR SUPPLIER		(1) (3)		TREET ADDRESS, CITY, STATE, ZIP CODE		
TRIAD CA	RE AND REHABILITATIO	ON CENTER	.1		07 NORTH ELM STREET		
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F 272	Continued From page	and the second s	71	F 272			•
	· ·	indicated that when a	4.4	The state of	1000 (400) 200 (400) 200 (400)		
		restraint, it would be					
		nt on a form under the the the the the the the the the the	152	6-4-5	[17] 是自己的特殊。		
		ne resident's medical (%) 3 refer*					
		explain the reason for the					
		also be noted on the care			1 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		
		into place. Nurse #17	ij.				
		ce was assessed to be a 🗼	**************************************				
		coded as such on the MDS	. 1	14.	[1] 医基乙酰 (1) (1) (1) (1) (1)		
	in Section P.		4		· · · · · · · · · · · · · · · · · · ·		-
	During an observation	n on 11/8/13 at 3:30PM,					
		nalf naked with top portion of	1				
		h the door open. Resident?	r	2.0000000000000000000000000000000000000			1
		anted to get out bed and go	•				
		it had a parameter bed and 📜		423.0	1 多类特别的 1		
		r place and half side rails			Participal		
		nfused and holding onto side			[1] "我们就是我们的		{
	rails,	p of the bed bulster and side	, i				1
	Talis,	三足科 二生学 结准数	11	1			
	During an interview o	n 11/8/13 at 3:45PM,	- }				
	Nurse#15 indicated ti		* 1				
		nine the need for the use of 4	Ai via	i de mar	[1] [1] [1] [1] [1] [1] [1] [1] [1] [1]		
		th bed bolster and it was not					
	considered a restrain			1 1 10	· · · · · · · · · · · · · · · · · · ·		
	During an interview o	л 11/8/13 at 4:05PM,the	4				1
		cated that a new program	- 1	.,			
		d to assess for the use or	1	ļ ·	【八字诗》的 数字镜 静,		
	need for bed bolster/g	parameter beds in the same	11				
		would be on the newly 🤚 🦠	1				
		acility and staff would be		1	▲ 「一」というとは「「「「」」という。		
		curacy of assessments for		1,1,			
	devices.						
	A follow-un interview	was conducted with Nurse "		** : : :			
		O PM. During this interview.		100			
	L		**	1 .	1		I

DEPART	MENT OF HEALTH AND HUMAN SERVICES					0; 11/26/2013 APPROVED
	S FOR MEDICARE & MEDICAID SERVICES	1				0. 0938-0391
STATEMENT O	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA? (X1) PROVIDER/SUPPLIER/CLIA? (Δ1) PROVIDER/SUPPLIER/CLIA?	:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE	
	345172	j.	B. WNG		1	08/2013
NAME OF P	ROVIDER OR SUPPLIER	34	. 8	STREET ADDRESS; CITY, STATE, ZIP CODE		
TRIAD CA	RE AND REHABILITATION CENTER	i,		NORTH ELM STREET HIGH POINT, NC 27262		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (* * * * * * * * * * * * * * * * * * *		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETION DATE
	· · · · · · · · · · · · · · · · · · ·	95	1000	DEFICIENCY)		
F 272	Conlinued From page 28	11 65 45	F 272		i.	
	she confirmed that the MDS nurse was not					
	responsible for determining whether or not a		* 1			
	device was considered to be a restraint and that it was up to the nurse managers to do that.			10 支撑。 图 13 13 13 13 13 13 13 13 13 13 13 13 13		
		1				
	An interview was conducted with Nurse #15 on 1	1		1 - 2000 含葉數學的 * -		
	11/8/13 at 4:15 PM. Upon inquiry, Nurse #15			1		
	stated the nurse managers for each unit were responsible for completing a restraint assessment	di G				
	form for each resident who had a restraint. She"	1	1 M A 1 .			
•	indicated the Interdisciplinary Team (IDT)	4,				
	determined what was considered a restraint and	, :				
· - ·	what was not through group discussion.	1				
	An interview was conducted with the DON on	,				
	11/8/13 at 4:34 PM, Upon inquiry, the DON stated	,				
	that if a resident was having any kind of falls and	is t	*			
	there was a need for a restraint, the issue would in be discussed in an IDT meeting, a care meeting.			The state of the s		
	and/or stand up meeting. The meeting would	21. 21.				
	involve a verbal assessment and discussion	: (1.5	上,你都能们我们我们		
	among the team members. No written	4	1.1			
	assessment tool would be produced during this	- j				
	meeting. The DON indicated that if a resident was determined to have a restraint in place, a " i i	Ä,	1 1	· · · · · · · · · · · · · · · · · · ·		
	written restraint assessment would be completed	j - i				
	and placed in the resident's chart.	i.				
	1. 大型 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	51.				
	2. Resident #171 was admitted originally on	11.				
	6/21/2012 with diagnosis that Included	21	,			
	schizophrenia and dementia.		1 1			
	A review of Resident #171's Minimum Data Set (MDS) dated 10/17/13 indicated Resident #171	,				1
	was severely cognitively impaired with impaired 1	3		10.7 编版编辑		
	short term and long term memory. Resident	; ; ;				
	#171 indicated symptoms of depression daily,1 11.			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	trouble concentrating on activities, and	1.	3 , 3	本 · 人名英格兰 计连续模型		l

A STREET FOR MEDICARRE & MEDICALD SETTYLCES TATURATION OF CORRECTION AND PROPERTY OF CONTRICT OF CON			ID HUMAN SERVICES		100	(1) 多编版的 特 拉		APPROVE AGGRAGGE
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F 272 Continued From page 27 reallessness. Resident #171 did not have any behavior problems and required extensive assistance with personal hygiene, folial use, dressing, and bed mobility. The resident was not coded as having a restraint in place. A review of Resident #1714 medical record revealed a Care Plan dated 7/31/13 with a risk for falls related to impaired mobility on one of the facused problems. Interventions in place were encourage resident to communicate prosence of pain, assist to reposition for corrifort, alarm to wheelchair, alarm to bed, floor mat, place in open area, refer to therapy for increased falls, place alarm box out of reach of resident since he turns the alarm off himself, incontinence care after funch, anti-slip pad to wheelchair, ensure call light is in place, lay resident down when tired or agitated, perimeter mattress, offer resident to be out of bed up to whoelchair when realless or gallated ae resident allows, give pain medications as indicated, anti-tipper and anti-rollback bars to wheelchair, resident to wear on silp footwear, remind resident to use call light prior to ambulating or transfer, therapy as riseded, and onsure environment is free of clutter. A review of Resident #171 to 11/5/13 at 10/00 AM showed a resident in bed with a portmeter mattress. Resident #171 to 11/5/13 at 10/00 AM showed a resident in bed with a portmeter mattress. Resident #171 to 11/5/13 at 10/00 AM showed a resident in bed with a portmeter mattress. Resident #171 to 11/5/13 at 10/00 AM showed a resident gigs over the edge of the mattress without his feet touching the.				¥.				(X5)
F 272 Continued From page 27 restlessness. Restleent #171 did not have any behavior problems and required extensive assistance with personal hygiene, tollet use dressing, and bed mobility. The restident wae not coded as having a restraint in place. A review of Resident #171's medical record roveoled a Care Plan dated /731/13 with at risk for falls related to impaired mobility as one of the focused problems. Interventions in place were encourage resident to communicate prosence of pain, assist to reposition for continot, alarm to wheelchair, alarm to bed, floor mat, place in open area, refer to therapy for increased talls, place alarm box out of reach of resident since he turns the alarm off himself, incontinence care after lunch, anti-alip pad to wheelchair, ensure call light is in place, lay resident down when fired or upitated, perimeter matiress, offer resident to be out of bed up to wheelchair when resiless or, apitated as resident allows, give pain medicalions as indicated, anti-tipper and anti-rolliback bars to wheelchair, resident to wear non slip footweat, remind resident to use call light plor to, ambulating or transfer, therapy as needed, and oncure environment is free of clutter. A review of Resident #171 to Physician Orders dated 6/21/12 to present did not indicate a medical need for or an order to use bed bolsters or the perimeter mattress. An observation of Resident #171 to 11/s/13 at 10:00 AM showed a resident in bed with a perimeter mattress. Resident #171 to 11/s/13 at 10:00 AM showed a resident in bed with a perimeter mattress. Resident #171 to 11/s/13 at 10:00 AM showed a resident in bed with a perimeter mattress. Resident #171 to 11/s/13 at 10:00 AM showed a resident in bed with a perimeter mattress.								
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		345172	ŧ	B. WING		11.	08/2013
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F 272	Continued From page	28 3 Sec. 34 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	3	.F.272			1
	12:00 PM showed a	esident who was dressed in	3		1. 在特别的基础的	•	
		s waist up. The resident	- 1 - 1 ii		[1] 大量 [1] [1] [2] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4		'
		nd was attempting to get out	67				1
		lent had his feet and legs			日本の日本の日本の日本の日本の日本の日本の日本の日本の日本の日本の日本の日本の日		
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		of bed. The bed alarm did	1	A par			'
	not alarm. The resid	ent was unsuccessful at 👍 🔻			1 1 1 1 1 1 1 1 1 1		
		d laid back down on his right] "			
	side,						
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		Aide #9 stated the perimeter					
		to keep the resident from					
	falling out of the bed.						
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	penneter mattress is	being used to keep the but of the bed.			A The Ball of t		
	As also down talling t	ducted with the Assist	1 1 2	1 4 July	【如杨龙花品种植】 [1] [4] [5]		
		ADON) on 11/7/13 at 7:30	4				
		ed the perimeter mattresses	* 1			•	
		as restraints but to cue the:					
		it of bed and to give the staff					
,		t there in time before he		* * * * * * * * * * * * * * * * * * * *			
	does fall. "		- 1				
			L3	40.0	1、沙娜也到到1900人		
		ducted with the Regional	4		1 计通信 医静脉形式	•	
		n 11/7/13 at 11:20 AM.	4.0 T	1			
		the Regional Director.					
	Consultant stated the	perimeter mattress and	241				
		ident#171 were not	5	1,512	上海 線接 計劃 11 美		
		ient because he is still falling					1
		er stated that the mattress			★ 一次的情報發酵子。		
		re prevented the resident			10 建品份素键100000		
		n the 14 times he did since into place. Upon further					
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		ess were not reassessed to	1		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		-
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	MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES		PRINTED: FORM A OMB NO. 0	PPROVED
STATEMENT C	OF DEFICIENCIES (X1) PROVIDENSUPPLIER/CLIA (CORRECTION LIDENTIFICATION NUMBER:		A BUILDING COMPLET	
	345172;	: د د	B. WING 11/08	/2013
NAME OF P	ROVIDER OR SUPPLIER	11	STREET ADDRESS, CITY, STATE, ZIP CODE	
TRIAD CA	RE AND REHABILITATION GENTER	滑. 6.	707 NORTH ELM STREET HIGH POINT, NC 27262	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	f	TAG CROSS REFERENCED TO THE APPROPRIATE	CONSTITUTE CONSTITUTE DATE
		73.	DEFICIENCY	
F 272	Continued From page 29 #171's falls.	Fig. 17 Inte	F 272	
•	An interview with Aide #8 was conducted on 11/8/13 at 6:30 AM, Aide #8 stated the perimeter bed was being used for Resident #171 was to			
•	keep the resident from falling out of the bed. An interview was conducted with Nurse #11 on	in the second		
	11/8/13 at 6:29 AM regarding the general use of bolsters on resident's beds. Upon inquiry, Nurse #11 acknowledged some of the residents had			* >
	mattresses with bolsters in place because, " these people fall and get out of bed." She indicated that since side rails could not be used, the bolsters with straps may be used and that, "			
:	the bolsters keep them from falling. " An interview was conducted with the Director of			
	Nursing (DON) and Regional Director Consultant on 11/8/13 at 8:40 AM. During this interview; the DON stated, "We don't use an assessment for stated."			
	the bolsters due to it's not a restraint." 'Upon '" further inquiry regarding the reason for the use of bolsters on a resident's bed, the Regional	1		
	Director Consultant indicated it was because the resident(s) try to get out of bed. She stated that use of the bolsters, "slows them down."			
	An interview was conducted with Nurse #17 on 11/8/13 at 2:45 PM. Nurse #17 shared 1/4 responsibility for completing the MDS and she			
	indicated the MDS nurses were responsible for a completing Section P (Restraints) of the MDS assessment. When asked where this information			
	came from, the nurse Indicated that when a device was used as a restraint, it would be assessed as a restraint on a form under the bases.	**************************************		
	Assessment tab " in the resident's medical record. In addition, there would be an MD order.	•		

	MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES		No.		PRINTED: 11/26/2013 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4:	(X2) MULTIPLE A. BUILDING	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172		B. WNG		C 11/08/2013
NAME OF P	ROVIDER OR SUPPLIER	2. Pr		STREET ADDRESS, CITY, STATE, ZIP CODE	
TRIAD CA	RE AND REHABILITATION CENTER	+ 143 143		07 NORTH ELM STREET	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	を 書い	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER OF THE	D BE COMPLETION
F 272	Continued From page 30	. š	3 5 070		
1 212			F 272		
	which would usually explain the reason for the restraint, and it would also be noted on the care.	1.5		[1] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4	
	plan when it was put into place. Nurse #17			[1] · · · · · · · · · · · · · · · · · · ·	
	reported that if a device was assessed to be a				
	restraint, it would be coded as such on the MDS				
	in Section P.				
		a (#.)	7.4		·
	A follow-up interview was conducted with Nurse			上 自己 网络正常 禁煙的 医生物	
	#17 on 11/8/13 at 4:00 PM. During this interview	7		▲ 网络沙鸡沙鸡	
	she confirmed that the MDS nurse was not responsible for determining whether or not a:		N.		
•	device was considered to be a restraint and that i			】 《	
	was up to the nurse managers to do that.				
		· ()		10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10	
	An interview was conducted with Nurse #15 on				
	11/8/13 at 4:15 PM. Upon inquiry, Nurse #15	<u>. 3:</u>	.:		
	stated the nurse managers for each unit were				
	responsible for completing a restraint assessmen		"		
	form for each resident who had a restraint. She indicated the Interdisciplinary Team (IDT)				}
	determined what was considered a restraint and		' '	【· · · 整座塔 網 注篇 * / / · ·	ļ
	what was not through group discussion.				
			4 9 4	1 人类的原始特殊	
	An interview was conducted with the DON on	1.7		1	
	11/8/13 at 4:34 PM. Upon Inquiry, the DON stated				
	that if a resident was having any kind of falls and	**.			
	there was a need for a restraint, the issue would	. 1			
	he discussed in an IDT meeting, a care meeting, and/or stand up meeting. The meeting would	d		1 人名英格兰克 经基础证券	
	involve a verbal assessment and discussion	. <i>i</i>			
	among the team members. No written	1 4-1			
	assessment tool would be produced during this				
	meeting. The DON indicated that if a resident		st :		
	was determined to have a restraint in place, a				
	written restraint assessment would be completed	. !!	1	十二二等性 [法] 對於	
	and placed in the resident's chart.		A		
	2. Donistant de una adultat - scrittor			10000000000000000000000000000000000000	
	Resident #1 was admitted on 5/7/1999 with a diagnosis of shoxic brain damage. Resident #1's				
	, anagripala di ariboto di arit dalliago, i tobidelli fi i S				ı

	MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES	***		PRINTED: 11/26/20 FORM APPROVI OMB NO. 0938-03	ΕĐ
Statement C	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/	vin A	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION (X3) DATE SURVEY COMPLETED	
	345172 (1)	5	B. WING	C 11/08/2013	Ì
NAME OF P	ROMDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	
TRIAD CA	RE AND REHABILITATION CENTER	74 S		707 NORTH ELM STREET HIGH POINT, NC, 27262	
(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 (AS) (EACH CORRECTIVE ACTION SHOULD BE COURLETION COURLETION COURLETION COURLETION COURLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	×
E 030					
F 272	Continued From page 31		F 272		
	cumulative diagnosis included aphasia, dementia, anxiety, depression, and psychotic disorder,				
	A review of Resident #1's medical record	34			
	revealed the resident had a past history of falls	1.7			ı
	but had not had a fall since 8/2/12.				
	A review of Resident #1's Minimum Data Set	1			
	(MDS) dated 10/2/13 indicated the resident was				
	totally dependent on staff for activities of daily	: :			,
	living (ADL). The MDS stated Resident #1 was		1.1		į
	ambulatory with one person assist. The resident	100			ļ
, ,	was not coded as having a restrain in place.				
	A record review of the Physician Orders dated	10			
	8/2/12 through current orders did not reveal there				
	were any concerns identified with falls or the need				:
	for a bed bolster or perimeter mattress. There		":"		
	was no Physician Order or therapy screen for the	ì	1		
	use of the perimeter mattress or bed bolsters.				
	10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	1 1 1 1 1 1 1 1 1		
121	A review of Resident #1's Clinical At Risk			10g 10g	
١,	Evaluation (CARE) Meeting Minutes Form indicate there was a CARE meeting on 8/2/12 but	-1		1. 新疆特别的 1. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	the minutes from the meeting did not indicate	į,	g seed		
	what the meeting was for. There was a notation	4			
	on the meeting minutes form that stated " 8/2/12	L.		A Million of the state of the s	
	ensure bolsters in place and secured " This was	•			
	crossed out and written below that was "niurses".				
	to ensure safety percautions in place during	11			
	round @ shift change ". The resident's last				
	CARE meeting was on 8/16/12 and concerned	1	1.0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	Resident #1's biting of her fingers with interventions of hand splints/ace wraps and a		1.00		
	Wanderguard to be placed on Resident #1.	- 4 - 4			
	A Share of the control of the contro		4		
	An observation of Resident #1 on 11/4/13 3:30	10		上。《 科》的科科 教》	
	PM revealed the resident lying in bed, in the	1		本 大概的形式 持 有12000	
	supine position with a perimeter mattress that had	1			

		MEDICAID SERVICES		4 4 4		!	FORM APPROVED
		MEDICAID SERVICES		ore transie	ADDOTOLONAL .		OMB NO. 0938-0391
	DÉ DÉFICIENCIES FORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	Y BRIFDING T	CONSTRUCTION		(X3) DATE SURVEY COMPLETED
				V POURDING _	\$ 19 \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	の表すでは、いっという。 H表現を明めては	С
		345172		8, WING			. .
NAME OF P	ROVIDER OR SUPPLIER	The same constant to be at \$	<u> </u>		TREET ADDRESS, CITY, STATE,	ንነዕ ሶለበፍ	11/08/2013
TWENT OF T	NOTIBELL OR GOLL CELL		1	1 235	07 NORTH ELM STREET	2 done	
TRIAD CA	RE AND REHABILITATIO	ON CENTER			IGH POINT, NC 27262		
(X4) ID		ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	3.	ID '		N OF CORRECTION	E COMPLETION
PREFIX :		SO IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCE	E ACTION SHOULD B D TO THE APPROPRI	
		<u>- 作为可以 比亞家語數</u> 。	3			CIĘNCA) -	
		1. 新到 1. 医经验检验 3. 经数据	9	3	- "具体证明机	The second	
F 272	Continued From page	32	3	F 272	2017年 - 1986年 - 1986年 - 1986年 - 1986年 - 1986年 - 1986年 - 1986年 - 1986年 - 1986年 - 1986年 - 1986年 - 1986年 - 1986年 -	連州では、 運動である。	
		d bed bolsters on either side				3	
		fent #1 was not able to	Ã.	100			ļ
	communicate her nee	de secondary to her	2			(事法)(2.5	
		re of her surroundings within	8	1 Televisi	A. A. 155 特		
		ye contact when spoken to				N.	
	or when someone en					G N	
-	residents call bell was		į,	4			
		ent #1 on 11/5/13 at 2:30 PM					
		in a rock and go chair	.;	٠.,	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	cream.	h Nurse #15 eating ice (1)	· .			į	
	Gedin.		14			\$ 1.	1
	An observation of Re	sident #1 on 11/6/13 at 2:30		i			
		fent lying in bed with	(i)				
	bolsters in place on e	ither side of her within a		Y production	The same of the sa	¥.	
	perimeter mattress.				[17] 化二磺酰胺 医电影		
					he swife ii ii ii		
P 1 (ducted with Aide #8 on		·• · · · ·		1	
		garding the general use of mattresses on resident's					
	beds. During this into		4		医二唑磺酰胺 對日		
		rs on the resident's pads	1	4		*	
		residents from felling out of	in t	1/1			
		julry, Aide #8 stated the	• 1	1,		.	
	residents with perime	ter mattresses that have the	¥42				
		e being used to keep the 😘 🦠		7,444		r.	
		out of the beds also. Aide					
		vhy some residents have	-77				
	both the boisters with	the perimeter mattresses.		9 000		ļ.	
	An intontiou was con	ducted with Nurse #11 on	7	,			
		garding the general use of:			k "糖"。 12.14		
		s beds. Upon inquiry, Nurse	1		[17] 人物使品致	ģ.	
		me of the residents had	4.1			4	
•	mattresses with bolst	ers in place because, "				ratio (ca	
	these people fall and	get out of bed. ! She	24.				
	indicated that since si	de rails could not be used,		**		1	
		s may be used and that, "	,				
	the bolsters keep their	n from falling, "				9 -	

		MEDICAID SERVICES	- 13: - 28: -				1APPROVED 1.0938-0391
SYATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA !! IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
			4:	7.00.20.110	A TOTAL STATE OF THE STATE OF T	,	c 1
		345172		B. WING		· I	08/2013
NAME OF P	RÓVIDER OR SUPPLIER			s'	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	<u> </u>
TBIAD CA	RE AND REHABILITATIO	M CENTED		7(OT NORTH ELM STREET		
INIAUGA		IN CENTER	i.	н	IGH POINT, NC 27262		_
(X4) ID PREFIX TAG	(EACH DÉFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	\$1.55 B. 12	ID PREFIX TAG	PROMDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ÀCTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) ETAU
		1. 15 中央 1. 1874 66 25 高工	51	The fact of	Decloient 7		
F 272	Continued From page	33		F 272			
	Nursing (DON) and R	ducted with the Director of a legional Director Consultant					
		A. During this interview, the on't use an assessment for	C_{i}				}
		s not a restraint." Upon	. 1				
		ing the reason for the use of	• (
	bolsters on a resident	t's bed, the Regional	1				
		idicated it was because the	ris.				
	use of the bolsters, "	out of bed. She stated that	1.				
	doo of the bolotore,						
		ducted with Nurse #17 on 📜			5. 是 海 15% (四) [[] 6. 4 5 5 5		
	11/8/13 at 2:45 PM.		7 is				
		pleting the MDS and she Irses were responsible for	1		The second secon		
		(Restraints) of the MDS	ki.				
		asked where this information.					
		indicated that when a 🛴 🧓	ş:		1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -] . ,
		restraint, it would be	. :				
•		int on a form under the " 🦠 🦠 the resident's medical	1	11111			
		nere would be an MD order	: '				
		explain the reason for the 👍	1.				
		also be noted on the care	7				
		into place. Nurse #17 / 4 / ce was assessed to be a					
		coded as such on the MD9.					ļ
			1) 1) 1)				
		was conducted with Nurse in	7.	1 1111			
		0 PM. During this interview,	5	1.1			
_:		e MDS nurse was not had a					
		ed to be a restraint and that it					
		nanagers to do that:					
			1.				
		ducted with Nurse #15 on			10000000000000000000000000000000000000		
	11/8/13 20 4:15 PM,	Upon inquiry, Nurse #15	25				

	MENT OF HEALTH AND HUMAN SERVICES	() 		PPROVED
STATEMENT (CORRECTION IDENTIFICATION NUMBER:			RVEY
			B. WING	12013
NAME OF P	ROMDER OR SUPPLIER	~; ;;;	STREET ADDRESS, CITY, SYATE, ZIP CODE	2010
TRIAD CA	RE AND REHABILITATION CENTER		707 NORTH ELM STREET HIGH POINT, NG 27262	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	1	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
·	Sign of the second of the seco	· (*	4. Septiment	
F 272	Continued From page 34	ei in in	- F 272	
	stated the nurse managers for each unit were			
	responsible for completing a restraint assessment	ere.	To Park To 数数据 1882 1882 1883 1884 1885 1885 1885 1885 1885 1885 1885 1885 1885	
	form for each resident who had a restraint. She indicated the Interdisciplinary Team (IDT)			
	determined what was considered a restraint and			
	what was not through group discussion.		1	
	An interview was conducted with the DON on			
	11/8/13 at 4:34 PM. Upon inquiry, the DON stated			
	that if a resident was having any kind of falls and			
	there was a need for a restraint, the issue would be discussed in an IDT meeting, a care meeting,			
14.	and/or stand up meeting. The meeting would	i i		
	involve a verbal assessment and discussion			
	among the team members. No written	:		
	assessment tool would be produced during this			
	meeting. The DON indicated that if a resident		The second of th	
	was determined to have a restraint in place, a		A TOTAL CONTRACTOR OF THE STATE	
	written restraint assessment would be completed			
	and placed in the resident's chart.	1		
	A Partie and the same of the s		[4] [2] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4	
	Resident #23 was re-admitted from an acute care hospital on 9/27/13 with a discharge has a second care.	ë.		
	diagnosis of altered mental status likely			
	secondary to aspiration pneumonia. His	Ä,		
	cumulative diagnoses included a history of			
	cerebrovascular accident (CVA or stroke) with	1		
	dysphagia, dementia, and seizure disorder 🔠		1	
		i		
		'n		
		1		
	decision making. Resident #23 was totally	i.		
	dependent on staff for locomotion and required	. :		
	extensive assistance for all other ADLs. There			
	were no behaviors nor rejection of care noted on	į.		
į	the MDS. Coding of the MDS indicated that no			
j	restraints were used for this resident.	15		
		: 1	1	

		MEDICAID SERVICES "	111	4			FORM APPROV 30-8890, ON BMC
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	٠,	(X2) Militaries e	CONSTRUCTION		(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	:1 :1	A. BUILDING	, , , , , , , , , , , , , , , , , , , ,		COMPLETED
				1			С
		345172	37	B. WING		<u> </u>	11/08/2013
NAME OF P	KOVIDÉR OR SUPPLIER	1. 图 [] P. L. D. E. D. E. J. L. Chengle			TREET ADDRESS, CITY, STATE,	ZIP CODE	
TRIAN CA	RE AND REHABILITATI	ON CENTER	<u>.</u> ! .	7	07 NORTH ELM STREET		
HUMB UM	CONTO INTIMOTE IN		1. P.	<u> </u>	IGH POINT, NC. 27262 📳		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES TO THE STATE OF THE	18 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	IO PREFIX		N OF CORRECTION ACTION SHOULD BE	(XS)
PREFIX TAG	REGULATORY OF	LEC IDENTIFYING INFORMATION)	3	TAG	CROSS-REFERENCEC	TO THE APPROPRIA	- :
		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	Ţ,		DEFIC	YENCY)	
						(}- }	
F 272	Conlinued From pag	je 35 - 6 (1 - 1 - 6 - 6 (1 -		F 272			
		t#23's 10/25/13 Care Plan					
-		physical restraints was not	. 7	1 1 1 1 1 1 1	1. 建维油抗算		
		er, a Focus Area related to the	1.0			多い。	
	resident's nek of fall Interventions:	s included the following	is.			<u>5</u>	1
		ate Initiated 8/29/13; Revision	4.		and good and all		
	on 10/9/13)				1000 新加州 1964		
	-Out of bed (OOB)	in geri-chair (a specialized 🖑					1
		nen restless/agitated as	3			<u> </u>	
		e Initiated 5/7/13, Revision on				5) Y	
	10/9/13) Parameter mattres	A las data anta-n	7		l i gi mahili	i i	
		s (no date noted) :: c : ! : ! : place; position appropriately ::	iń,		1		
		te (Dated 10/4/13)					
	,	W. Carle	:		4	₹ : ·	1
		nducted with the Director of	7]		
		Regional Director Consultant	21				
		M. During this interview, the	- 11	"		8	
:		lon't use an assessment for." t 's not a restraint. " Upon :			1000 横桥设备	•	1
		ding the reason for the use of	3		八貫 徳禄詩	11	1
		nt's bed, the Regional		4		1	
	Director Consultant	indicated it was because the			[1] "杨"杨琦		
	resident(s) try to get	out of bed. She stated that			1. 泛维地 包件	1	
	use of the bolsters,	" slows them down. "					
	An interview wer co	nducted with Nurse #17 on	5.			4. 4.	
		Nurse #17 shared	3				
		npleting the MDS and she 🏋					
	indicated the MDS r	iurses were responsible for 🖔				į.	1
		P (Restraints) of the MDS	4				
		asked where this information					
		e indicated that when a				*	
		a restraint, it would be a limit on a form under the "				\$	
		the resident's medical			[1] 獨雄[54]	<u>1</u>	
		there would be an MD order		100		¥ 1 .	
	which would usually	explain the reason for the	H H	1		*	
	restraint, and it wou	ld also be noted on the care 🤚	(†) 80			P	

	MENT OF HEALTH AN		1			FORM APPROVED
	RS FOR MEDICARE & I				<u> </u>	OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROMOER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		A. BUILDING_	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			ri ·		10 · 10 · 10 · 10 · 10 · 10 · 10 · 10 ·	С
		345172		B. WING	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	11/08/2013
NAME OF P	RÖVIDER OR SUPPLIER		1 347		STREET ADDRESS, CITY, STATE, ZIP CODE	!
TRIAD GA	RE AND REHABILITATIO	IN CENTER	選出	1	707 NORTH ELM STREET	
Timerice Gy	the Man see to the Hart	A CONTRACTOR OF THE CONTRACTOR	:;	1	HIGH POINT, NC 27262	
(X4) ID		ATEMENT OF DEFICIENCIES	75 A	ָר פו	PROVIDER'S PLAN OF CORRECTION	
PREFIX		Y MUST BE PRECEDED BY FULL: LSC IDENTIFYING INFORMATION)	j*	PREFIX	CROSS-REFERENCED TO THE APPROPRI	
TAG		LOC IDENTIF TING INFORMATIONS	.1	TAG	CROSS-REPERENCED TO THE APPROPRI	P(IC
	ļ	10 A A A	7	 	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
E 070	A. N					
F 272	Continued From page	الهراك والأشار المناها المناها المناها المناها	1	F 272	化学院的经验的建筑技术	
		into place. Nurse #17 🕏 🐍 .	4.	The Robert Re	1、100.000000000000000000000000000000000	
		ce was assessed to be a	i -		♣ 行政機能的政策的等置的分析。	
2.5		coded as such on the MDS	A60 A60 130		小難深的 壁積積積	
	in Section P.	100多年高級企業額份	- (3	1、数点设有情况以数据2000年	
•		A section of the sect	33			İ
		was conducted with Nurse	1			
		0 PM. During this interview,	1:		斯斯 的转基进行。	
		e MDS nurse was not				
		nining whether or not a		1	1 1	
		ed to be a restraint and that it				
	was up to the nurse n	seuedera to no mar	4	4		1
•	An interview was con-	ducted with Nurse #15 on		, A	扑 点引起数 (2) 14 3 3 3 3 3 1 3 3 3 3 3 3	
:		Jpon inquiry, Nurse #15	40	1	1. 後端線 马拉勒	1
. •		agers for each unit were		-		
		eting a restraint assessment	S	41 - 1 - 1		
		t who had a restraint. She		1. Sept 1.	10 《第二》等。持續的方式	
	indicated the interdisc				人認識性的對射的 。	
		considered a restraint and			The state of the s	
	what was not through		4,			
	•		3.			
	An interview was cond	ducted with the DON on 🙀 🗽			植 马龙科教育新疆教育	
	11/8/13 at 4:34 PM. U	pon inquiry, the DON stated	11	7.3000	[1] [2] [2] [2] [2] [2] [2] [2] [2] [2] [2	Table 14 Page 1
		having any kind of falls and	()	^	[1] 1. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
*. 1		a restraint, the issue would	!</th <th></th> <th>1 人姓氏伊马克特第分。</th> <th></th>		1 人姓氏伊马克特第分。	
		T meeting, a care meeting,			【 下海 10 元/40 页页重集器 1 元 元 元 元	
		ing. The meeting would				
		ssment and discussion		4		
ļ	among the learn mem					
		d be produced during this	,		■ 2. 人名英格兰人名 集集 (1)	
		dicated that if a resident				
		ve a restraint in place, a	. j.			
		sment yould be completed	(1.7)			
- 000	and placed in the resid				F309	
1	483,25 PROVIDE CAI		+ -1 11	√F 309		
\$\$=D	HIGHEST WELL BEIN	1G		` · i	1. Resident #218 Insulin orders wer	·e
					reviewed, and clarified with the	
-	Each resident must re	ceive and the facility must	1		Physician on 11-7-13.	
1			1		(FDV3(LID)(U) 11-/-13.	

		ND HUMAN SERVICES MEDICAID SERVICES	1			FORM): 11/26/2013 MAPPROVED), 093 <u>8-0391</u>
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	Survey Leted
1			;	A BUILDING_		,	: 1
		345172	\$ t \$t	B. WING			08/2013
NAME OF PE	ROVIDER OR SUPPLIER		· i.	S	TREET ADDRESS, CITY, STATE ZIP CODE		
TRIAD CA	RE AND REHABILITATI	ON CENTER	- -		07 NORTH ELM STREET HIGH POINT, NC 27262		
(X4) ID PREFIX		NATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	14' .	ID PREFIX :	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	Ē	(XS) COMPLETION
YAG.	REGULATORY OR	LSC IDENTIFYING INFORMATION)		, TAG	CROSS-REFERENCED TO THE APPROPRIA	YE.	DATE
			71 L				
F 309	Continued From pag	27	15	F 309			
F 303	· .			F 309	Lange Agrice Language And Challe Public		
		ry care and services to attain est practicable physical,	7		orders will be reviewed by 12-6-13 i	or	
	mental, and psychos				accuracy.		
		comprehensive assessment		1 1 1 1	3. The Licensed nurses were		
	and plan of care.		• •		In serviced on		
			1		admissions/readmissions verificatio	n	
			•		of orders by Staff Development Coordinator (SDC) by 12/06/13. The		
	This REOLIBEMEN	T is not met as evidenced			11-7 nurses will check the		
1	by:	i is not that as a nadinger			Admission/Readmissions orders		
		lews and staff interviews, the	1		against hospital discharge		
	facility falled to obtai				summary and discharge medication		
		insulin coverage for 1 of 3	*	,	list for accuracy. The nurse will initia	ıl	
		ceiving insulin, and failed to	174		on the Discharge Medication list after		
		blood glucose results 🔠 🤾		7 4 4	verifying.	-1	
	with diabetes. (#218						
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1		4. The DNS or designee will review the	he	
	The findings include:	1	4	4 1 7 7	new consolidated orders upon		
			11		admissions, readmission, quarterly		
		as admitted to the facility on	1		assessments and change of condition	ή -	
		tal. Her cumulative	3.	1	Any finding from the review will be	.,	40.406.443
	infection and aphasi				brought to the PI meeting each mon	th	12/06/13
		mpairs a person's ability to	24		for the next three months.		
	use and comprehend	J language).	1. "	**			
		sident #218 was assessed by e severely cognitively				:	
		cision making skills. The		grade d			
		lent on staff for all Activities	4.				
	of Daily Living (ADL		11				
					The state of the s		
		medication orders for	-				,
		led the following: Humulin R		1.0			
}	insulin 100 unit/millili	ter (mi) solution given three times a day	,				
		se was specified in the	el e				
		ed on 11/2/13 and signed by	. t				

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			:					FORM	11/26/2013 APPROVED
STATEMENT (S FOR MEDICARE & DEFICIENCIES CORRECTION	MEDICAID SERVICES (XI) PROVIDER/SUPPLIER/CLIA () IDENTIFICATION NUMBER:		(X2) MULTIP		NSTRUCTION			*	MB NO. (X3) DATE S COMPL	
,		345172		B. WING		1 (1)		di di		C 11/0	8/2013
NAME OF P	ROMDER OR SUPPLIER	三直的 自身的林), 23,			ET ADDRESS		E ZIP CODE			
TRIAD CA	RE AND REHABILITATIO	ON CENTER	13		2.75	IORTH ELM I POINT, N		· 新文	i į		
(X4) ID PREFIX TAG	 (ÉACH DÉFICIÉNC 	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EAC	ROVIDER'S P H CORRECT LREFERENC DE	IVE ACTION:	SKOULD BE		(XS) COMPLÉTION DATÉ
					3 7			18			
F 309	Continued From page	∍ 38	-7	F 30	9 ;		11 300	\$ 0.11 \$ 0.11			
	the prescriber on 11/3	3/13.						4.2			
	A review of the Medic	ation Administration Record								1	
		2013 revealed the following	; ;								
		e MAR for Resident #218;						3 1			
		three times a day before elow 200 no extra insulin;	51				-1. F		•		
	200-250 give 2 units;	251 - 300 give 4 units;	1			7 14 1				Į	
		351-400 give 8 units; 401 -	7.		٠ ,						
		1 to 500 give 12 units;	3			. (1) (1)		1		[:
9- 1	Insulin. Recheck blo	od sugar in 2 hours at that				179.1 198.2				1	
	time if blood sugar is	above 400 or under 100	i.				10 - (10)			[
	notify physician.	cks and sliding scale insulin	; ; ;	1					-]	
		fuled on the MAR at 6:00	1								
	AM, 11:00 AM, and 4				.				· •		
	 Further review of the	MAR for November 2013	4							1	
	revealed the sliding s	cale insulin was			-	terk Side					
	1	dent #218 on the following			ľ	. 1				-	
	dates and times: 1 time on 11/2/13 at	9:00 PM:	:			**************************************	で見る。 20 4 6年まで		,	1	
	1	6:00 AM, 11:00 AM, and									
	4:30 PM;	A.A.A. 212 1.44.A.A. 214	11,			1 12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
	1	6:00 AM and 11:00 AM; 1 3 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1			į.					
		6:00 AM and 11:00 AM; and	¥1.			4.4		4 2	•		
	1 time on 11/7/13 at	5:00 AM.	1						.*		
	An interview was con	iducted on 11/7/13 at 11:46		40.00							
	AM with Nurse #15 w	vho assumed responsibility				مبحث الأدام. فعولات					
	as the Unit Manager	Director. Upon review of the	11		.	**		1 1	,		
		ecord, Nurse #15 indicated Discharge Medication						1			
		Rec) from the hospital was									
	used as a basis for the	ne admission medication	; : '			- 1 (ij)	4-1,		•		
	orders dated 11/2/13	Nurse #15 indicated the	:					٠ ۽ ڏِ ۽			
	Discharge Med Rec	had a hand-written notation	- 1	1		1.5.	:	11.2			

		ID HUMAN SERVICES					PROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		T		OMB NO. 0	938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SUR COMPLET	
		345172	***************************************	B, WING		C - 11/08/	2013
NAME OF P	RÖVIDER ÓR SUPPLIER	1947年中華國籍第一	7	5	TREET ADDRESS, CRY, STATE, ZIP CODE		
TRIAD CA	RE AND REHABILITATIO	ON CENTER	: : :3		OT NORTH ELM STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES: Y MUST BE PRECEDED BY PULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE ¢	OX5) OMPLETION DATE
			-11				
F 309	Continued From page	39	- (; - (; - (;	F 309			
	on it which document	ed the list of medications				1	}
	had been verified by	the prescriber on 11/2/13, 🧃	2 kg			. 1	
	After a brief review of	the Med Rec, Nurse #15	<u></u>	The Part of the			
		ut that the list of medications			· 计可引擎的 医高囊囊 医心口	}	
		d Rec included Humulin R			10000000000000000000000000000000000000	l	
		e times a day in a dose		1		1	
		its. However upon further	3		1 12 战争转骤1		
		ge Med Rec, Nuise #15					
		was a checked box labeled	11		· · · · · · · · · · · · · · · · · · ·		
		o the Humulin R insulin.		ļ ,			
		on, Nurse #15 referred to	-1				
		nsulin Sliding Scale (SSC)		1 2	1-		
		he insulin dosages on the 👍			The state of the s		
		cted those of the facility's	,	M 71 W 7			
		s orders for Resident #218					
		viewed with Nurse #15.	1				
	There was no docum		.:	1			
		nich indicated an order had	4	1		1	
		lation of the facility's Regular				ļ	
		protocol for this resident			上。 "我们也就是特别的。"	}	
	Triadini Ciloning October	protocol for this testagnic in the			Marie Control of the	•	
	A review of the facility	y's Regular Insulin Sliding					
		ed that when ordered, the	1			1	
		following: " Blood Sugars				-	
		less otherwise specified by	4.	1 19 2 2 2	1 · 没好的人并不是多人。	1	
		ent #218 was receiving					
10 E		vith Regular Sliding Scale	14	1 111			
	insulin given three tin		1				
	uisami Aisan duas m	nes daily.	- 4				
	A fallow up rovious of	Resident #218's medical	17				
	record revealed the f				事。	}	
			1:	ŀ	★ おおおり 接着の ***	1	
	1	escriber on 11/7/13 at 2:10		. "		1	
	PM:	evemir insulin, Discontinue	77			1	
	three times daily (TIE				The state of the s	1	
			f:				
		30 units SQ every night at				Į	
	bedtime (HS)	and sugge (EODO) hafare	11			1	
		ood sugar (FSBS) before				1	
	meals at bedtime (AC	CHS) daily			1		

		ID HUMAN SERVICES	1.		ORM APPROVED 3 NO. 0938-0391
		MEDICAID SERVICES	•		DATE SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/GUPPLIER/CLIA IDENTIFICATION NUMBER:			OWNERLED
		医三氢异合 医多变移属的	•		С
		345172	13	B. WING	11/08/2013
NAME OF P	ROVIDER OR SUPPLIER	3 1 2 7 7 4 8 8 2 7 3 7	1	STREET ADDRESS, CITY, STATE; ZIP CODE	
				707 NORTH ELM STREET	
TRIAD CA	RE AND REHABILITATIO	ON CENTER TO ALM TO ACCUMENT	3	HIGH POINT, NC 27262	
(X4) ID		ATEMENT OF DEFICIENCIES	ei.	10 PROVIDER'S PLAN OF CORRECTION PREFIX PEACH CORRECTIVE ACTION SHOULD BE	(X5) GOVPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULLY (1): LSC IDENTIFYING INFORMATION)	11.	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE	DATE
			23	DEFICIENCY)	
	· · · · · · · · · · · · · · · · · · ·	7 - 1	,		
F 309	Continued From page	e 40	\mathcal{F}_{i}	F 309	
		with sliding scale per nursing			
	protocol with Humulin		1	1. 5. 2011 (1972) 2012年 [14] (14) [14] [15] [15]	
		10 units SQ every AM			ļ
	O) Lantas mauni				
	A follow-up interview	was conducted with Nurse	.]		
		80 PM regarding the facility's	7		
•		admission medication orders	- ()	□ 2000 1.0 \$350 \$2 \$\$ \$100	
		urse #15 indicated the facility	1		
		discharge summary from the	- 21		1
		that the facility's nurse would	1.		
	be responsible to cal	l and get a medication list			- 10
	from the discharge s	ummary confirmed by either		A day of the state	
	the physician or nurs	e practitioner.	1	数数数据 医阿尔克斯特氏系统系统系统	
		17 (2) 医生产 号 李肇传(4)			
		nducted with the Director of a			
		1/8/13 at 4:34 PM regarding			1
		ing admission medication 🔞 🥏	5		
		ents. The DON reported that	1		Ì
		y had admission orders when	1		
		ng those for medications,			
		er expectation would be for			
		s to be confirmed with the		1. 人名英格兰 (A. 1985) [1] [1] [1] [1] [1] [1] [1] [1] [1] [1]	
		nd any changes in the orders	i i		
	to be noted as bart o	f the admission orders.	1		
	2) Regident #218 vs	as admitted to the facility on	in		-
		tal. Her cumulative	1		
		diabetes, urinary tract	- 1		
		a (a disorder of			
		impairs a person's ability to			
	use and comprehend		1		
			:		
	Upon admission, Re-	sident #218 was assessed by	4.	事 した 【リー族 別 砂糖製品 マーニー	
	the nursing staff to b	e severely cognitively " "	1 1		
	impaired for daily de-	cision making skills. The	j		
		ent on staff for all Activities :	1.	■ 1. 大阪・大阪・大阪・大阪・大阪・大阪・大阪・大阪・大阪・大阪・大阪・大阪・大阪・大	
	of Daily Living (ADLs	> 自由自由自由自由基础表现表现的	- 1		1
		一一門 特别 违法援责令人			1
	The list of admission	medication orders for 1916	2		-

		MEDICAID SERVICES			<u> </u>	A Age as				MAPPROVED 0. 0938-0391
		777			· .			b :		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA : IDENTIFICATION NUMBER:		A BUILDING	± CONST	RUCTION	1	\$		SURVEY PLETED
			1	W ROLFOUNG "	,		- 1			
	•	345172	- 1	B. WING	*				1	Ç 'ag'asas
NAME OF ST	RÖVIDER OR SUPPLIER	440 MARIA (17. 17. 17. 17. 17. 17. 17. 17. 17. 17.	2:		TOPET	Opposed And	/ CYAPE '	na cons	1 11	/08/2013
TOWNE OF PI	TOVIDER OR SUPPLIER		* 1		4	ADDRESS, CIT		ar code		
TRIAD CA	RE AND REHABILITATIO	ON CENTER				TH ELM STRE DINT, NC 27		and the second s		
(X4) ID		ATEMENT OF DEFICIENCIES	***;	-10				OF CORRECTION		(X5)
PREFIX YAG		Y MUST BE PRECEDED BY FULL	7.7	PREFIX				ACTION SHOULT TO THE APPROP		COMPLETION
			1	"-			DEFIO			
		e e e e e e e e e e e e e e e e e e e	4.	N. S.		: 18 °	1 . 33	3		
F 309	Continued From page	41	+1	F 309						
,		ed the following: Levemir	34		E serv					
			37				Fig.	R. I		
İ		unit/milliter (mt) solution 10			1 1 1	5. 网络多 1. 网络多	17.43	*		1
	units subcutaneousty insulin 100 unit/mitlilit	(SQ) daily; and Humulin R	**	l Mr.			3 3	1. 4.		1
		er (nn) solucon iven three times a day	20			ta in Albania National Albania	100 A 2 著 。	∯ * + ‡		
		se was specified in the		1 "				∯ ≰		
		d on 11/2/13 and signed by	; ;							
•	the prescriber on 11/3		1 1	.,	-					
	the presented on The		:			4	1 1	ž.		ļ
	A review of the Medic	ation Administration Record	; :	[1	, t		\$		i i
		2013 revealed Resident	***	¥4.				į.		
		were checked three times **			1					1
		00 AM, and 4:30 PM.		*		in the second		6	*	1
		November MAR indicated		1 4 6		4. 14. 14.		1		}
	the following blood st	igar results were obtained:	,			\$1.00 mg		8		
	Blood sugar = 371 on	11/4/13 at 4:30 PM; Blood					4	10	•	
	sugar = 345 on 11/5/1	13 at 4:30 PM; and Blood	4							
	sugar = 381 on 11/6/	13 at 4:30 PM. Normal				1	子:"是 "	(第1941)		
		pically range from 60-99	j.,			الله الله الله	1004			Ì
		ng/dl) for a fasting blood 🤙 🔻	1			4	> 3 1	*行		
	sugar and below 140	mg/dl for a random blood 3.	2.	1		1 199	4	for the		1
	sugar.		74 24		1					
		1000年 中國共產黨等	1				4 ()	ř.		
	Further review of the		V).			A Same				
'		ed there was no record of				777		4		
		rded for the elevated blood			ľ			ų.		
		d on 11/4/13 at 4:30 PM,			1 .			į		
	11/5/13 at 4:30 PM a)	nd 11/8/13 at 4:30 PM,			1			åbut.		
	A anniani and the constale		. 1	"	1.	李 儲 45	1.1	\$117°		
		ent's medical record revealed all documentation of the	' ;		1	\$5 FFA		k .		
		results recorded within	-1		1 "	38		24.		-
		nary Progress Notes or the		1	1		1			
		nere was no documentation	-4	• 44		j k _i "''				-
		response to the elevated * ***		200	1					
	blood sugar results.	CONTROL IN THE GRANTER				W1 **	3. S.	7		
	arana nahai tasaila.	1 m	el.		1	the second		ģ		
	An interview was con	ducted on 11/8/13 at 2:15]		a G		N ·		
		parding documentation of						1		

		ID HUMAN SERVICES	-1:		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	FORM APPRO 0MB NO. 0938-0	
		MEDICAID SERVICES					1331
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION "	(X3) DATE SURVEY COMPLETED	
MDFDWG	COUNTEDITOR	IDENTIFICATION TOTAL	A	A BUILDING		'	
			, ,		2、李·蒙·安·省、特勒等。"	С	
		345172	1	D. WING		11/08/2013	
HAME OF P	ROVIDER OR SUPPLIER	The state of the s	2.1	8	TREET ADDRESS, CITY, STATE, ZIP CODE		
		i na manga kada da Alika, Mili	:1	7	07 NORTH ELM STREET		
TRIAD ÇA	RE AND REHABILITATIO	N CENTER	(d) 1		IGH POINT, NG 27282		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID.	PROVIDER'S PLAN OF CORRECTION	(XS)	
PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL 🤻 🤊	4	PREFIX	(EACH CORRECTIVE ACTION SHOULD B	COMPLET	ION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA	1E 5	
			- 24				
).	医色霉素 医骨类医腹囊炎					
F 309	Continued From page	· · · · · · · · · · · · · · · · · · ·		F 309		1	
	insulin coverage for e	levated blood sugar levels.					
		was a spot on the 💸 🐯	<i>.</i>	*	[1] 不可能的自己的基础的现在分词		
		cuchecks (blood sugar 💢 🦠	1			į	
		plood sugar results would be	4		Page 2000 2000 2000 2000 2000 2000 2000 2000 2000 2000 2000 2000 2000 2000 2000	·	
		ndicated that if the resident					
		n coverage, the number of	1		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
'		vould also be recorded on					
	the MAR.						:
	An intension was sone	ducted on 11/8/13 at 2:30	71				
		ho assumed responsibility	ا رداد			1	
		Director. Nurse #15 stated	117		1		
		od sugar was checked the					
		results and put her initials	L.)]	;
		coverage was provided, a c	S. Hill	3.0]	
		document the amount of 🌸	7			†	:
		AR. Nurse #15 reported "	- 1	1.1.8.3	Land China Carlot Carlot		
		given, the dose should be					
	noted on the MAR.		7)			Ì	
	•						
		ducted with the Director of,	- (jr		[4] (1) · · · · · · · · · · · · · · · · · · ·		
		8/13 at 4:34 PM regarding	, .	11		i	
		evated blood sugar results.	':		State of the state		
		at she would expect any	-1		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
		n elevated blood sugar level the resident's MAR. She				•	
Ì		documentation of insuling	A.				
		y did not need coverage. ""		N 45 4			
F 333	483 25/h) EREE OF A	CCIDENT		F 323	F323	1	
¢φ~U 1 Λέδ	HAZARDS/SUPERVIS	SION/DEVICES	-1	1,420	Faco	1	
33-0	TO BUILDING CITY			1			
	The facility must ensu	re that the resident	4,		1. Resident #20 and #171 fall care pl	ən	
		as free of accident hazards	1,1		was reviewed for effectiveness of		
	as is possible; and ea	ch resident receives 👉 🖖 🐇	,		Interventions on 12-2-13.		
	adequate supervision	and assistance devices to			· 人名 人名 大學學 ·		
	prevent accidents.			;			
			- C97 B		In extremely a service of the contract of the		
				196			1
1		The state of the s	- 1		Part A. Lewis — A. L. Martin Martin	1	- 1

	MENT OF HEALTH AND HUMAN SERVICES	-1				APPROVED
CENTER	S FOR MEDICARE & MEDICAID SERVICES 1	<u> 21</u>	,			0.0938-0391
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA CORRECTION UMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		÷i.			()
	345172	Ų i	B. WING		11/	08/2013
NAME OF PI	ROMDER OR SUPPLIER	35.	l s	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
		1		O NORTH ELM STREET		i
TRIAD CA	RE AND REHABILITATION CENTER			IGH POINT, NC 27262		
(X4) (D	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	.	(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL) REGULATORY OR LSC IDENTIFYING INFORMATION)	4	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		CAYE
"//~	1000 100 100 100 100 100 100 100 100 10	\$ · · · · ·	1 1 1 1 1	DEFICIENCY)		
	2		9	1000		
F 323	Continued Commune 42	2.3	E 202			
F 323	Continued From page 43		F 323	2 All other residents who have had	a	
		3		fall within the last 30 days will have		
			. 1 \ 1 \	their care plan reviewed for the		
	This REQUIREMENT is not met as evidenced	. 1	11	effectiveness of their interventions		
	by;			any necessary changes will be made	at	
	Based on observations, staff, and record reviews	1-1		that time.		
	the facility failed to assess and re-evaluate	2.5		The children of the children o		
	interventions put in place to reduce falls for	4		7 All martiness that had a few man to	_	
	residents that had falls and continued to fall for 1	* } ~		3. All residents that have a fell will b	e	
	of 2 sampled residents reviewed for falls			reviewed the next day and		
Ì	(Resident #171).			Interventions updated and all other	1	
	Findings included:		1	interventions reviewed for		
	Resident #171 was admitted originally on			effectiveness by the IDT team. The		٠.
	8/21/2012 with diagnosis that included continued		*	falls will be reviewed at]	
	schizophrenia and dementia.	\$ 1	46 (2)	the weekly Care Meeting by the IDT	.	
	A review of Resident #171's Minimum Data Set	1.				
	(MDS) dated 10/17/13 indicated Resident #171			team.		
	was severely cognitively impaired with impaired					
	short term and long term memory. Resident 📑	-11		4. The Director of Nursing/Designee		
	#171 indicated symptoms of depression daily, 😲			Will complete a weekly audit for 8	ļ	
	trouble concentrating on activities, and		9.	weeks then bi- weekly for 2 weeks. A	\]	
	restlessness. Resident #171 did not have any	N 7	19	finding will be brought to the Pl		
	behavior problems and required extensive			monthly for review and evaluation.	ļ	12/06/13
4, 5, 6,	assistance with personal hygiene, tollet use, *** ;		95.5	monthly for toyley and evaluation.		12/00/13
	dressing, and bed mobility. The resident was not				1	
	coded as having a restraint in place.	11	1 1 1 1 1 1 1			
	A review of Resident #171's medical record **	1				
	revealed a Care Plan dated 7/31/13 with at risk					
	for falls related to impaired mobility as one of the	1	į			
	focused problems. Interventions in place were:	- 14 - 14		[1] (4·杨] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4		
}	encourage resident to communicate presence of	,				
	pain, assist to reposition for comfort, alarm to			医神经线 鐵鐵 人名斯特勒曼氏征		
	wheelchair, alarm to bed, floor mat, place in open	4				
	area, refer to therapy for increased falls, place				ļ	
	alarm box out of reach of resident since he turns	돢	4			
	the alarm off himself, incontinence care after	0 -		医乳腺 医肾髓性肠囊膜炎		ļ
	lunch, anti-slip pad to wheelchair, ensure call light	11	4	[/		ĺ
	is in place, lay resident down when tired or	, ;		「ここの数据算数と関係教養課題を発生しました。 こことの数据算数の数据数素のあった。		
	agitated, perimeter mattress, offer resident to be	10.4		· · · · · · · · · · · · · · · · · · ·		
į	out of bed up to wheelchair when restless or			25 - 14 - 14 - 14 - 14 - 14 - 14 - 14 - 1		

(3)

		ALEDICAID SERVICES	.;		**				APPROVED
		MEDICAID SERVICES		г			- 1 5. - 2 5), 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROMIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	; ; ;	(X2) MULTIPLE A. BUILDING				(X3) DATE GOMP	SURVEY LETED
			;		7.		a filipania. A a filipania	- '	C ·
		345172		B, WING			1 1	11/	08/2013
NAME OF P	ROMDER OR SUPPLIER		1		TREETAL	DDRESS, CITY, STA	Te, zip code		
70140.04	DE AMO DELLABULTATA	an actives	1	7	O7 NORT	HELM STREET			
ININDCA	RE AND REHABILITATION	IN GENTER,	22	7 (4 % ₽	iiGH PO	INT, NC 27262			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	÷	10	T	PROMDER'S	PLAN OF CORRECT	ÓN	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDEO BY FULL 🔞 🖰	. 11.	PREFIX			TIVE ACTION SHOUL		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	- 11	TAG	F - 2		CED TO THE APPRO EFICIENCY)	PRIATE	JANE .
			30.		1	3 10 4 5	3 4 4		
			ű.			100			ļ
F 323	Continued From pag	e 44 1		F 323			建氯铁矿		
	agitated as resident	allows, give pain medications	À	3 3 5 6 6			就養的行 一		1
	as indicated, anti-tips	oer and anti-rollback bars to			1 1 13				
	wheelchair, resident	to wear non slip footwear, 🚯	14		10 11/				
		e call light prior to 🍃 🔆 🕸 🤊	٠.		11 14		李		1
		er, therapy as needed, and 🤭	1		1. 500				
		is free of clutter. The care	1.7				1		1
		falls when adding a new			ľ				<u> </u>
-		was no assessment or					1		
		rventions already in place		N. 1	-				1
	and their effectivene		4.1].	1031 · 1	15 1		
		#171's Physician Orders	,		1	一熟的统治 自			
		sent did not indicate a 👫 😘							
		n order to use bed bolsters	3-4	1			1		
	or the perimeter mat		-1		1				
	1	esident #171 on 11/5/13 at serident in bed with a	* }						
	1	Resident #171 had only an					1 7 1		
		and was seen with his legs	3			10 mm	1 1		-
		mattress without his feet	- : !				1 1		
	louching the floor.	manuess windut ins lest			,				
		esident #171 on 11/8/13 at	÷ ;.			, , , , , , , , , , , , , , , , , , ,			
		resident who was dressed in	1						
		is waist up The resident			1 .		481		
		and was attempting to get out	3				· 秦		-
		dent had his feet and legs 🧀	4,	** ***					
		perimeter mattress			1 .		4		1
		of bed. The bed atarm did	- : :						
		lent was unsuccessful at	• ;				44.6		
	getting out of bed an	d laid back down on his right	- 11						
	side.						1 6		
	1	iducted with the Regional				्रहें भारती			
		on 11/7/13 at 11:20 AM.			1.				
		the Regional Director.	١.					•	
		e perimeter mattress and			1		1 8 1		
		sident #171 were not	*)						
		dent because he is still falling:	e ja		l' -				
		ier stated that the mattress :		1 4 1	1 -	4.5			
		ve prevented the resident	* 5	1	1	100			
	from falling more the	n the 14 times he did since	٠,		1 .	1	4 t 1		1

					museen assessed
DCOADT	MENT OF HEALTH AND HUMAN SERVICES		<u>.</u>		PRINTED: 11/26/2013
					FORM APPROVED
CENTER	S FOR MEDICARE & MEDICAID SERVICES : 1		,		MB NO. 0938-0391
	OF DEFICIENCIES (X1) PROVIDER/BUPPLIER/CLIA**	11.	(X2) MULTIPLE	CONSTRUCTION (X3) DATE SURVEY
AND PLAN OF	CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		COMPLETED
			Į į	1 新心化 (支援事)	С
	345172		B. WNG		11/08/2013
	<u></u>	;;			11/00/2013
NAME OF PI	RÖVIDER OR SUPPLIËR			TREET ADDRESS, CITY, STATE, ZIP CODE	
	MILE AND REAL PROPERTY OF THE	75	7	OF NORTH ELM STREET	
TRIAD CA	RE AND REHABILITATION CENTER			IIGH POINT, NC 27262	
	AUGUSTA DU BELTELICUE AC DECIACUAICA	1.5.		PROVIDERS PLAN OF CORRECTION	~~
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (SEACH DEFICIENCY MUST BE PRECEDED BY FULL)		ID PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
PREFIX YAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	4.0	TAG	CROSS-REFERENCED TO THE APPROPRIAT	
		6. "		DEFICIENCY	
	e variable en en en en en en en en en en en en en			THE REPORT OF THE STATE OF THE	
		441			l
F 323	Continued From page 45	9.1	F 323.	1. 《 新安·西·安 诗	
	the devices were put into place. Upon further				
	inquiry the Regional Director Consultant stated	Ų			
	the bollers and mattress were not reassessed to	(1)		[1] 的,就是以某个特殊的。	
	see if they did or did not decrease or increase	٠, ,	1 y 3 m . 9	To Part 1987 1987 美国特别的图片	
		, y	1	1、1、1、1200年,艾特斯·蒙蒙古一一	
	TOOLGER IFT TO TORIST	- 11 -			
	An interview was conducted with the Director of			│	
	Nursing (DON) and Regional Director Consultant.	1		lour, the policy below	
	on 11/8/13 at 8:40 AM. During this interview, the	4			
	DON stated, "We don't use an assessment for	1			
	the bolsters due to it's not a restraint."				
	An interview was conducted with the DON on		,	17、18、18、14、14、14、14、14、14、14、14、14、14、14、14、14、	
	11/8/13 at 4:34 PM. Upon inquiry, the DON stated	- 1			
	that if a resident was having any kind of falls and				
	there was a need for a restraint, the issue would				
	be discussed in an IDT meeting, a care meeting.		4 .	[图] [[] [] [] [] [] [] [] []	
	and/or stand up meeting. The meeting would		1 . 1		
	involve a verbal assessment and discussion		1	■大点 如5 PK 常用[基業][14]	
	among the team members. No written			[19] G [1] [2] [2] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4	
	assessment tool would be produced during this			1000000 100000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000	
	meeting.		1 6	Company Real Barrier	
F-328	483.25(k) TREATMENT/CARE FOR SPECIAL 1	6	F 328	F328	
\$\$=D					
0.00		111		A B II Francisco	
·	The facility must ensure that residents receive	V.	1	1. Resident #220 received a full	
	proper treatment and care for the following	7		tank of Oxygen on 11-06-13.	
	special services:	71.		∤	
		1			
	Injections;	1-4			
	Parenteral and enteral fluids;] ;		
	Colostomy, uraterostomy, or ileostomy care;				
	Tracheostomy care;	- ; -		1	
	Tracheal suctioning;	2.1	1 60	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	
	Respiratory care;	٠,	1		
ľ	Foot care; and	;		1	
	Prostheses.		· .,		1
		5 į.		The state of the s	
	14 · 大学舞台为	17		トール star in the table in the table in the table in the table in	
1	This REQUIREMENT is not met as evidenced				
j	by:				
j	**	6-4			1
}			I		1 1

			- 11	•	ment.	ITED: 11/28/2013
DEDART	MENT OF HEALTH AN	IN HUMAN SERVICES				ORM APPROVED
		MEDICAID SERVICES	;			NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA'.		OVAL MULTIPLE		DATE SURVEY
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	1 :	A. BUILDING		OMPLETED
			1); vi	A BOILDING_	The state of the s	c
	•	3	27.0			
		345172.	<u> 21 - </u>	B. WNG		11/08/2013
NAME OF P	ROVIDER OR SUPPLIER		t		TREET ADDRESS, CITY, STATE, ZIP CODE	į
TOUAD CA	OF AND DEMARK STATE	IN PUNTED	4.1		DY NORTH ELM STREET	
INIAUCA	RE AND REHABILITATIO	A CENTER OF THE SUPPLIES	ñ	H	IGH POINT, NC 27262 1	
(X4) 1D	SUMMARY STA	ATEMENT OF DEFICIENCIES		ID .	PROVIDER'S PLAN OF CORRECTION	¢(5) COMPLETION
PREFIX		Y MUST DE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR L	.sc identifying information)	3	TAG	CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	
		一名 美国人名英格兰 建氯化	, \ 		別の記念の表現の	
F 328	Continued From page	46 [[[[[]]]]]]	4	F 328	2. All the residents that had oxygen	1
	Based on observation	n, staff interview and record	¢. ,		were reviewed on 11-6-13. If a tank	
	review the facility falls	ed to provide continuous	115		Was low it was replaced. Nursing	
* *	oxygen for 1 of 16 Re	sidents. (Resident #220)	47 .		Management updated resident care	
	,		71		cards to alert staff when a resident is	
,	Findings included:					
					on oxygen and was placed on inside of	
		dmitted on 10/9/13 with the	; ;	•	residents closet. All rehabilitation	
		ure, peripheral vascular	1		therapist were in-serviced by Genesis	i i
		enxiety. Review of the most			Respiratory Therapist & SDC on	
!		Set dated 10/21/13,	• •		11/07/13 on the importance of oxygen	
		ong or short term memory:	21		therapy, timeliness of changing e-	Ì
		le to make decisions of his	- <u>1</u> 1 "	Magnetic A	tanks, how to properly change and	
		d extensive assistance with			set-up e-tanks, location and storage of	İ
71 1		hygiene. He received	3		oxygen tanks. Maintenance	
	oxygen therapy.		1		Department will check oxygen closets	•
,		t and the state of				
	Review of physician		1		and replace empty tanks on a daily	
		oxygen 2 liters per minute	1.		basis	
	bý nasel cannula.		- 1			
	Daniano as mbunialas a	order dated 11/1/13,	7		3. All residents using E tanks and who	
		oxygen) at 2LPM (liters per		,	have orders for oxygen saturation	
	minute) NC (nasal car	nnula).	74	The first	levels every 4 hours daily will be noted	
	minute) NO (modifical	midday.	•	***	on the routine MARS, If tank is less	
	During an observation	on 11/6/13 at 9:57 PM,		+ +3 /	than 500 PSI the tank will be changed.	
		20 was on contact isolation				
7		sitting at the sink in his		••	4. Unit Manager/designee will Audits	į l
		sal cannula was in his nose	4			
		oing was lying on the floor.	1.19		MAR weekly for oxygen sats and tanks	
	No oxygen was in the		•		checks on weekly basis for 8 weeks,	
	portable tank. Residei				then by weekly for 4 weeks.	12/06/13
		he opposite side of his				
	room and was off. Aid	de #5 was in the hall putting	- 1			
		equipment. During				1
		icated she was going to 🙏			医肠管 競戲 医多霉素质 化二二二二二二二二二二二二二二二二二二二二二二二二二二二二二二二二二二二二	
		re. When asked if resident	14.		1000 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	
		oxygen she sald '" Yes ".	4			
		ical therapist brought him	1			
	back from therapy and	3 left him sitting there	!		医三角 建二氯甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基	

			- ' - '				
		ID HUMAN SERVICES	71. ·			FO	ED: 11/26/2013 RM APPROVED IO: 0938-0391
STATEMENT (OF DEFICIENCIES	(XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLI	E CONSTRUCTION A STATE OF THE S	(X3) DA	TE SURVEY MPLETEO
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	1.	A. BUILDING			
		345172	11:	B, WING	・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・		C 1/08/2013
NAME OF O	ROVIDER OR SUPPLIER	340172			STREET ADDRESS, CITY, STATE, ZIP CODE		1/00/2013
	10 miles	· 医甲酚 自動養養	i ili si Ma	Je .	07 NORTH ELM STREET		
TRIAD CA	RE AND REHABILITATIO	N CENTER	- M		HIGH POINT, NC 27282	· ·	
(X4) ID PREFIX	(ÉAOH DÉFICIENC	ATEMENT OF DEFICIENCIES Y XX		ID PREFIX,	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL	DBE	(X5) COMPLETION DATE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	10	TAG	CROSS REFERENCED TO THE APPROI	MAIE	0.112
,	,		14.				
F 328	Continued From page	48	3	F 328			
	i	his oxygen off anyway, and	- 3 - 35	- 7			
		de#5 should have obtained.	1				
	the oxygen prior to st	arling incontinent care.	4.	1	10 20 11 12 12 12 12 12 12 12 12 12 12 12 12		
	Parata and taken days de	1/6/13 at 10: 30 am, the	-				
		pectation was a resident	4				
		en ordered to have oxygen	٠,	N 4, 4			
	on at all times.						
	During on Interview of	n 44/0/42 of 4:20 nm DOM					
•		n 11/6/13 at 4:20 pm DON - n in communication with				,	. ,
		erapist) and orienting them					
	to where the oxygen i	was stored. There was also.	. 1				
		wn with Aide # 5 who had	- 1				
		ined oxygen for resident #.					
F 364		RITIVE VALUE/APPEAR,	V 1	F 364	F364		
SS=D	PALATABLE/PREFER			10.00		•	
	a		4.	,	1. Residents #89, #221, #132 #1	37	
		s and the facility provides hods that conserve nutritive	÷.		were interviewed by the		
		earance; and food that is	ં.		Dietitian/FSD on 11/29/13 conce	rning	
	palatable, attractive, a	and at the proper		1	food preferences. Management	-	l l
	temperature.				monitored tray delivery on 11/6		
			-		11/7/13, & 11/18/13 to ensure t		
	This REQUIREMENT	is not met as evidenced : «		1	delivery of meal trave		
	by:			1	delivery of mean trays.		
		servation, staff interviews '					
	and resident interview	is and beverages for 2 of 4	4				
	halls to resident prefe		. V				
	ž		34				
	The findings included			1 16	1 人名德尔拉特维尔 电		
	Durino an interview o	n 11/5/13 at 10:00 AM,	į				
	Resident # 89 indicate	ed lunch and super was not	~ 1				
	good and there were	concerns with the					
				 A control of the contro	雅 こうしゅうしき こうしょう おばしをした		

		ID HUMAN SERVICES	> 4 • :				MAPPROVED 0. 0938-0391
		MEDICAID SERVICES	1	1			
	óf deficiencies FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE COMP	LETED
		■ こうぶん Hot 会議的意志	₹*:	ا تراهد .	17.10.10. 网络拉拉多名穿刺囊科 19.000	1 1	0
	The state of the s	345172	- 1	B. WING	· · · · · · · · · · · · · · · · · · ·	11/	08/2013
MAREOER	ROMDER OR SUPPLIER .		- 11	1	TREET ADDRESS, CITY, STATE, ZIP CODE	1	00,2010
WALKE OF F	ACMIDER ON OUTFLIER			**	OT NORTH ELM STREET		
TRIAD CA	RE AND REHABILITATION	ON CENTER			IIGH POINT, NG 27262		
(X4) ID		ATEMENT OF DEFICIENCIES	25, 2	4 ID. 10 1	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX		Y MUST BE PRECEDED BY FULL 1	- 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD I)E	COMPLETION
TAG	REGULATORY OR	LEC (DENTIFYING INFORMATION)	1	TAG	CROSS-REFERENCED TO THE APPROPRI	ME.	•••
			7.5				
				1.55			
F 364	Continued From page	3 49 TENNE	14.	F 364	2. Residents having the potential t	o pe	
	preparation of the me	al and the meal choices. 🔧	* 63		affected by this practice were		
			1				
	During an interview of	n 11/5/13 at 11:13 AM, 🗟 🖟	1		Identified by conducting random		i
		ted all the meals were			interviews of residents		
	served cold and she	had to go reheat the meals .			on 12/02/13 by the Dietitian		
	herself. Resident #22	11 added that this concern;	i	*	concerning palatability of food an	4	
	had been brought to t	the attention of several of 🙏 🕆	? ?			•	
	the staff with no chan	ge.			timeliness of tray delivery. An		
		4. 公共等。	- 1		additional food cart is being utilize	d on	
		onducted on 11/5/13 at 🗀 🦠	* .		two halls to reduce the amount of		
		#132 indicated that he had	· ~i		time the trays are walting to be		
. '	trouble eating the fco		3		}		
		he eats in his room and the	11		delivered which will ensure that fo	φ¢	
		in the hallway for some time	1		is at proper temperature. On		
		in and the food was typically			11/18/13, the Food Service		
	cold.		1	,	Director (FSD) re-implemented the	. 1/4	
	During a kitchen obse	ervation on 11/7/13 at	Ĺ		1	- / 4	
		ok the temperature of the	1		pint cartons of milk which aids in		
		n the presence of dietary	ei.	l 1 15 1.	meintaining proper temperatures.	The	
		gistered dietician (RD),			plate warmer was serviced by the		
,		vith temperatures with of	. :		Maintenance Director on 12/02/1	3 &	
. (warm. The beverages had			temperatures are maintained.		
·		e last cart left the kitchen at	i.	ag all and	temperatures are maintained.		•
•]		was served on the floor at 🧎	21.			;	
		cluded regular/pureed pork 🐇			3. The Nursing staff was in-service	d on	
	chops, regular/pureed		1.		12/03/13 by the Staff Developmen	ıt	
		potatoes. The beverages	á		Coordinator (SDC) concerning time	-lv	
		d tea. Test tray was set-up					
		nom tasted the food and			delivery of meal trays, asking resid		
	proceeded to take ter was sampled with the	nperature of food. The food			if their meal is warm enough and r	6-	
	was sambled with fue	tollowing results:			heating the meal if needed.		
	The DM (distant man	ager) and RD took the	:j-		The Food Service Director/Dietitia	n in-	
		lowing items regular/pureed	: : :		serviced Dietary staff on 11/06/13		
. [dry and not hot at proper	31.				
		wy, regular/pureed cabbage	;		ensuring proper temperature of fo	od	
ļ		ivor with the pureed	4.1	4	prior to meal service.		
-		oes luke warm, the thicken	1	h .			

			- "		murco asmonoto
	MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES	i i			RINTED: 11/26/2013 FORM APPROVED MB NO. <u>0938-0391</u>
STATEMENT (OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 	(X2) MULTIPLE A. BUILDING		X3) DATE SURVEY COMPLETED
	345172		B. WNG		Ċ 11/08/2013
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
TRIAD CA	RE AND REHABILITATION CENTER	14 13 14 6	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	07 NORTH ELM STREET	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	. 1.	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL !	2	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	;	TAG	CROSS REFERENCED TO THE APPROPRIAT	[‡] [
		11			
F 364	Continued From page 50	}	F 364	4. The Dietitian and FSD will conduct	:
	Juice and tea was very warm.		= }	food palatability interviews	
		14 21		weekly times 4 weeks then monthly	
	DM indicated that the food or the beverages were			1 ベル・ミーエー しゅうしょうきぶん りゅうしがた サー	
İ	not served at proper temperature when the cart	4.	100,4	times 2 months and report the	-
	reached the floor. DM added he was aware of the		٠.,	findings to the Pi committee month	y -
	resident's concerns regarding cold food through	i al		times 3 months to ensure compliance	9
	individual residents and resident council group.			and consistency. Menu Meetings wil	l l
	DM further stated the expectation would be the			1	'
	food and beverages remain at proper 🛒 🔑 🗀		-	be held weekly times 4 weeks and	
	temperatures when delivered to the halls and the			then monthly. Temperature test tray	15
	dining room. In addition, new kitchen equipment	- 13		to be completed by the FSD/designe	e
	would be purchased to address the problem.	4		3 times per week times one month	
	During an interview on 11/7/13 at 5:28PM,	1	1		
	Resident #137 indicated that his lunch was cold	· .		then weekly times one month, then	
	when it arrived at 1:30PM. He indicated that the	1: "		monthly.	12/06/13
	meals are normal late about 30 minutes and very		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	12.0	
	cold. Staff indicated that they did not have time to		t and the second		
;'	reheat the food when asked. He indicated the				
	process has been when the meal was delivered	4			1
	to the hell it sat on the hall another 30 to 40	. 1			
	minutes before it got to the room. He indicated	•			į
	that he has complained to nursing and dietician:			10000000000000000000000000000000000000	·
	He indicated that they also run out of food as well	**1 ;		· · · · · · · · · · · · · · · · · · ·	
	and they couldn't even get an alternate. He also	- Ni			
	indicated that some of his cold beverage would;				
	come hot or not at all. He indicated that a 🖟 🐣	i	1 4741 .	[1] (A) [\$P\$ [4] [4] [4] [4] [4] [4] [4] [4] [4] [4]	
	grievance had been filed in September regarding			[1] A. W. W. M. M. M. M. M. M. M. M. M. M. M. M. M.	
	the food temperature and late arrivals of meals,	4		医多类性 級 诗集化文	
	but nothing was changed. He further stated that	:	age of the Cal	人以为此"是""表现是	
	the meal on 11/7/13, cabbage and sweet				
	potatoes were cold and juice was luke warm	1 1	.,		
	when it should have been cold, had to ask for ice.	1:		1000年1月1日 100日	
	The chicken was not hot but he tolerated it is			小家沙科養養養養	
	because he was hungry.		. نر .		1
		- 1			
	During a follow-up interview on 11/7/13 at	- 51 "		17 (2009) 14 (19 19 19 19 19 19 19 19 19 19 19 19 19 1	•
	5:35PM, Resident #89 indicated that all the food			1000 高麗 医抗乳糖素的	
	comes out cold and that they trays sat on the hall		1	▲ こうしゅうしょう 大手事の	1

	MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES	FORM	: 11/26/2013 APPROVED : 0938-0391
	OF DEFICIENCIES (X1) PROVIDENSUPPLIENCIA (DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE COMPL	.ETED
. :	345172	B. WING 11//) 8/2013
NAME OF PI	ROVIDER OR SUPPLIER	SYREET ADDRESS, CITY, STATE, ZIP CODE	
TRIAD CA	RE AND REHABILITATION CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262	,
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (ÉACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 364	Continued From page 51	F 364	
	for 30 minutes or more. He indicated that he had		
	reported this concern on several different		
	occasions and no one has time to reheat the food.		
	Ouring an interview on 11/7/13 at 5:35PM, NA#4 indicated that residents had complained of cold [1]		
	food and on occasion would request for the meal		
	to be reheated. The microwave was located in mini kitchen.		
	Ouring an interview on 11/7/13 at 5:40PM, NA#6 indicated that there had been some complaints about cold foods and the expectation was staff		
	should reheat the food. There were also complaints about the trays coming up late. NA#6 indicated that there was a microwave on the		; *
	behavior unit, and mini kitchen located near nurse station. There was no micro wave in the dining		
	room.		
	During an interview on 11/7/13 at 5:46PM, NA#7 indicated that there had been reports of cold food	を表現している。 ・	
	and the expectation was to take the food to the microwave down the half to warm up the food.		
	During an interview on 11/7/13 at 5:48PM, the		
	DON indicated that there were no microwaves in		
	the dining room per the company to prevent the tresidents from getting burned and they were by the stress of the s		
	more secured in other locations. The expectation		
	would be if the resident complained the food was		
	cold staff would go to the designated area to warm the food.		
	During an interview on 11/7/13 at 6:10PM, line	引 " 本 本 多 新 的 舒 的 。	
	Administration indicated that she was aware of	利 《 图 图 图 图 图 图 图 图 图 图 图 图 图 图 图 图 图 图 	
	the residents concerns with meals temperature		

		D HUMAN SERVICES	4				MAPPROVED 0 <u>, 0938-0391</u>
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/SUA		(Val to a Web E	CONSTRUCTION	(X3) DATE	
	of Deficiencies Correction	IDENTIFICATION NUMBER:	10	A. BUILDING			felen
	,	· Problem Market	1.5	, cuitoma_			С
		345172	71	B. WING		1	08/2013
		343172	1):		THE PROPERTY OF THE PARTY AND PARTY.	1 110	00/2013
NAME OF P	ROVIDER OR SUPPLIER	1000年1月1日 1000年1月1日	4.		TREET ADDRESS, CITY, STATE, ZIP CODE		
TRIAD CA	RE AND REHABILITATIO	N CENTER			07 NORTH ELM STREET		
					IIGH POINT, NC 27262.		y
(X4) ID		ATEMENT OF DEFICIENCIES	11	10	PROVIDERS PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL	į.	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	IATE	BIAG
17.10		三日本 医三角生巢管膜炎			DEFICIENCY)		
		The second second					-
F 364	Continued From page	62		F 364	10000000000000000000000000000000000000		
	address the concerns	the first terms of the first ter	•		[1] 文 唯 [1] <u>\$\$</u> 建 氯的5		ļ
F 674	l .			F 371	F374		
F 371	483.35(i) FOOD PRO		े हैं। इंड	F 3/1	F371		
SS=F	STORE/PREPARE/S	ERVE - SANITART	2 ²	1.4-5.]
	The facility must •	人名英格兰 医多种线管炎			1. All areas identified during the		İ
		sources approved or	7		survey were discarded; all meal po	ots.	
		ry by Federal, State or local		4	and pan were rewashed		
	authorities; and	, 2, 1 dania dia 2 3 1	÷.		and stored appropriately, sliced		
		stribute and serve food		.,	melon was discarded immediately	,	
	under sanitary conditi		.,		and meal service, was stopped		
			4.1	. " :	and the identified dome lids and b	ases	
	:		1		were rewashed and		
			24. 1		dried appropriately. On 11/08/13,		
			- 11 1		Ecolab serviced the dish machine	for	
				, ,	proper drying.		
		is not met as evidenced	4		proper arying.		
	by:	The state of the s	5		[1] [1] [1] [1] [1] [1] [1] [1] [1] [1]		
		ns, staff interviews, and	H				
		roduce, in 1 of 1 walk in					
		f 4 meal carts, ensure the	- } '				
		le pots and pans on the dry			10000000000000000000000000000000000000		
		ean, dry and free from dried		1			
		drying racks, discard an	200	111			
		that had fruit flies in/out of	110				1
		dry dome lids/insulated	1				{
	bottoms and store the	m on a clean cart/racks.	4.				
	٠,						
	The findings included		7		F - 新秋 日 新韓 F 1 1 1 1		
			- 1		【一周 超显色图 "接著人员"		
		tion of the walk in freezer on	1		多數數數數學數學		
		box of rotten spoiled mushy	;		1000 A 2000 A 2000 A 2000 A 2000 A 2000 A 2000 A 2000 A 2000 A 2000 A 2000 A 2000 A 2000 A 2000 A 2000 A 2000 A		
	· ·	eppers was mixed with	-1		(1) 不是 经基本		
.	fresh produce.		11.				
	During an intention of	11/4/13 at 4:05PM; the	, ,				
		indicated that there should	- '		1、1、1、1、1、1、1、1、1、1、1、1、1、1、1、1、1、1、1、		
		stored with fresh produce in					
	ne no rough produce:	Moreo ann nean bronnea m	.:1				

					DDINTER): 11/26/2013
DEPART	MENT OF HEALTH AND HUMAN SERVICES	1.4	•			APPROVED
	RS FOR MEDICARE & MEDICAID SERVICES	.;				, 0938-0391
			<u> </u>			
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA F CORRECTION LIDENTIFICATION NUMBER:	- (3) - (4)		CONSTRUCTION	(X3) DATE	BURVET LETED
LAID L D-G1 (3)	POOR CONTROL OF THE PROPERTY O	2.1	A BUILDING			
	State Control of the	1			(;
	345172		B. WING	<u>一、中、沙科等的特殊</u> 會事情可能。	11/0	08/2013
NAME OF P	ROVIDER OR SUPPLIER	- 1		STREET ADDRESS; CITY, STATE, ZIP CODE		
		3		07 NORTH ELM STREET		
TRIAD CA	IRE AND REHABILITATION CENTER			HIGH POINT, NC 27262.		
						
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL.)	2.2	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	.	COMPLETION COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS REFERENCED TO THE APPROPRIA		DATE
		7	25 4 25 3	DEFICIENCY	1	
********	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	35 1		more the tell of the tennel.		
F 371	Continued From page 53		17 974	2. The Fond Service Director (FSD) to	,	
1.073	1 2 5 6 852	J_{i}^{\prime}	F 371	complete daily checks of walk-in	l	
	the refrigerator.	f l	·	cooler for items needing to be		
	1000 1000 1000 1000 1000 1000 1000 100	33	1.	discarded, out of date items, and		
	2. During an observation on 11/7/13 at 12:15PM,	14		proper food rotation/storage.		į
	4 meal carts had dry brown matter and food		181132	Environmental Services Department		
	debris stored on the cards.	-	:	will pressure wash all food carts on a		
					'	
	During an interview on 11/7/13 at 12:30PM, RD			weekly basis and dietary Staff to		
	and DM indicated that the meal carts should			sanitize between each meal. On		ł
	cleaned and wiped down daily before trays are	11		11/08/13 EcoLab serviced dish	ļ	
	placed on the carts by the kitchen staff.	13		machine to include adjusting Rise Ale	d i	
		,		(Drying Agent) to aid in proper dryin		
	3. During an observation on 11/7/13 at 12:15PM,			and also checked the 3 compartmen		
	14 silver steam table pots and pans were stored	2.3		sink sanitizer and soap dispenser for		
	on 2 drying racks greasy with dried food debris		1			
	and 7 sectional plates and low lip bowls were dirty		i establica	proper function. Maintenance direct	or	İ
	with dried food particles were stacked on top of	- '		Increased dish machine water	ŀ	
	one another in preparation for use during the			temperature to aid in the drying		l
	meals,	3		process. FSD/Cook to complete spot	İ	,
	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			checks daily of pots and pans and	1	i
	During an interview on 11/7/13 at 12:30PM, the	,		dishes. Stacking and storage of dome	a [
	register dietician(RD) indicated that kitchen staff	1		lids and bases are racked individually		
	responsible for ensuring the pots/pans and dishes			to allow for proper air drying.		
	were clean prior to usage and stored clean on the					
	designated racks.	*1	l di di	FSD to completed daily spot checks t	٥	
				ensure that dome lids and bases are		
	4. During an observation on 11/7/13 at 12:15PM,			dried prior to stacking.		
	1 bowl of 14 1/2 sliced melons in a large silver		77 1 7		1	
	bowl and silver storage pan located on top of the	٠. ا	• *	3. Re-educated dietary staff on		
	dirty sink dated 11/4/13 with fruit files and nats		٠	11/07/13 by FSD & Dietitian on	1	
ľ	flying in/out of opened suran wrapping.	- []	· · · · · · · · · · · · · · · · · · ·	proper warewashing, proper air		ļ
	- M. C. J. B. B. B. B. B. B. B. B. B. B. B. B. B.	1				j
	5. During tray line observation on 11/7/13 at		1	drying, and kitchen sanitation.	1	ì
	12:35PM, 20 dome lids and 40 insulated bottoms	,	* 12 × 2	19 19 19 19 19 19 19 19 19 19 19 19 19 1		
	was stacked wat on top of each other on the	- 1	4	4. FSD will complete daily checks of		-
	drying rack with dried food particles. The DM	- 33		walk-in cooler times 4 weeks,		1
	identified the lids and dome as cleaned and ready	3.		then weekly times 2 months, then		-1
	to be used.			monthly. Environmental	1	
[During an interview on 11/7/13 at 2:30PM RD		7,1	Services Department will pressure		ŀ
	TOTAL AR INDOMENOUS TO A STATEMENT HOST		i	c	1	

	MENT OF HEALTHAN	and the second of the second o					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		· · · ·	THE STATE OF THE S	OMB NO), 0938-0391
	óf deficiencies FCORRECTION	(X1) PROVIDER/SUPFLIER/CLIA IDENTIFICATION NUMBER:		NULTIPLE ILDING	CONSTRUCTION	(X3) DATE ÇOME	SURVEY PLEYED
	•		4	-11			С
		345172	B, Wil	(G		11/	08/2013
HAME OF P	ROVIDER OR SUPPLIER	李克克 海河 经基础结束		. 8	TREET ADDRESS, CITY, STATE, ZIP CODE		
TOUR OF	SE Alio bellano trato	3	# 	7	DY NORTH ELM STREET		
HUAU ÇA	RE AND REHABILITATIO	NCENTER		H	IGH POINT, NC 27262		
(X4) 1D		TEMENT OF DEFICIENCIES		ID.	PROVIDER'S PLAN OF CORRECTION		(XS) COMPLÉTION
PREFIX TAG	REGULATORY OR L	/ Must be preceded by full sc identifying information)		EFIX :	(EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPR		DATE
109			· ·		DEFICIENCY)		
			13'			<u> </u>	
F 371	Cantia and Francisco		A .	- A-4			1
r \$/1	Continued From page			F 371	wash all food carts weekly.		
		training and cleaning in the	· -		FSD or designee to check pot and	•	
	kitchen would be con:	lucted immediately.			pans, dishes, dome lids and		
					bases daily times 4 weeks, then		1
		11/7/13 at 6:10PM, the	3		weekly times 2 months, then		
		ed that the DM and RD			monthly for cleanliness and prope	r	
		ocerns with the sanitation of			drying. All audits will be		
		ated that when the new	1		reported to the PI committee mor	41shu	
		ng/kitchen occur this should				шну	1
		problems. The DM will		Ì	times 3 months to]
	begin in-service with a			1.	ensure compliance and consistence	у.	12/05/13
	conditions in the kitch			ا د د پ			
F 431		UG RECORDS,	**	F 431	F431		
SS≂E	LABEL/STORE DRUG	is & Biologicals		en in de Grand			
	Tt - f - title				1. Expired medications on 1-		
		oy or obtain the services of who establishes a system :			North Cart #1, 1 south Cart#1,		
	of records of receipt a				and 2 south Cart #1, were		
		ficient detail to enable an	i i,		discarded appropriately.		
		; and determines that drug			Expired medications in the		
		nd that an account of all	<u> </u>		medications store rooms were		·
		intained and periodically	5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
	reconciled:			•	discarded appropriately.		
	recondição.				All medications not stored		}
	Drugs and high-dicals	used in the facility must be		12 - 1	as specified by the manufacture]
. ,		with currently accepted	,	. :	were discarded appropriately.		
	professional principles		<u> </u>		All other medications in carts		
	appropriate accessory		·		were audited for the medication w	ith	
	instructions, and the e				the resident name and/or		
	applicable.				expiration date	:	
	• •		,	1	1. 自由報告的表情多情的方面。		
	In accordance with Sta	ite and Federal laws, the			2. License Nurses will be in-service		1
	facility must store all d			,			
į	locked compartments	under proper temperature	94 T		on monitoring expired medications		
	controls, and permit or	ly authorized personnel to			and dating medication bottles whe	n - ∣	
	have access to the key				opened by Assistant Director of		
' 1				' . I	Nursing(ADNS)/SDC by 12/06/13.		
.	The facility must provid		.				
	permanently affixed co	mpartments for storage of				1	

				The first of the second of the	m. aardmindad
DEPART	MENT OF HEALTH AND HUMAN SERVICES		4		D: 11/28/2013 MAPPROVED
CENTER	S FOR MEDICARE & MEDICAID SERVICES	,		OMB NO	0, 0938-0391
STATEMENT (OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	1	(X2) MULTIPLE A. BUILDING		SURVEY LETED
			4		c
	345172	1	B. WING	2000 是一点的And And And And And And And And And And	08/2013
NAME OF P	ROVIDER OR SUPPLIER	24		TREET ADDRESS, CITY, STATE, ZIP CODE	
TOTAL	RE AND REHABILITATION CENTER	7	7	OF NORTH ELM STREET	
TRIAU CA	RC AND REHABILITATION GENTER	**		IIGH ROINT, NC 27282	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID ,	PROVIDER'S PLAN OF CORRECTION	6(2)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	램.	TAG	CROSS-REFERENCED TO THE APPROPRIATE	DATE
				DEFICIENCY)	
	in the second second second	3.1			
F 431	Continued From page 55	110	F 431	3. Unit Manager/designee will check	
	controlled drugs listed in Schedule It of the	ş.,			
		şŧ.,		the medication carts and medication	!
	Comprehensive Drug Abuse Prevention and	*		storage rooms on a weekly basis, for 8	
	Control Act of 1976 and other drugs subject to	Ö.	3	weeks then monthly for 2 months.	
	abuse, except when the facility uses single unit	100		Omnicare Pharmacy Representative	
	package drug distribution systems in which the			will do a complete audit of all carts	1
	quantity stored is minimal and a missing dose can		,	and medication carts for expirations.	
	be readily detected.	4		and medication carts for expirations.	
	• • • • • • • • • • • • • • • • • • • •			4. The DNS will be responsible over	
		:	ľ	the audits and the results of the audits	
	This REQUIREMENT is not met as evidenced	11		will be brought to the PI meeting	
	by:	1:	,	monthly for analysis and evaluation.	12/06/13
	Based on observations, record review and staff	,i	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	monthly for analysis end evaluation,	
	interviews, the facility failed to: 1) remove expired				
	medications from 3 of 9 medication carts (1-North	i i	1 1	Linear Age of the Control of the Con	l
	Cart #1, 1-South Cart #1, and 2-South Cart #1);			● 大海市公司会議事任任	
	2) failed to discard expired medications in 1 of 4"			Combined to the state of the st	
÷. ,	medication store rooms (1 North Medication	1.	1.15		}
ĺ	Storeroom); 3) failed to store medications as		7		
	specified by the manufacturer in 3 of 9				
	medication carts (1-North Cart #2, 2-North Cart	1			
i i	#1, and 2-South Cart #1); and 4) failed to label		1 1		
	medications with a resident's name and/or		100		
	expiration date in 3 of 9 medication carts (1-North			[187] · [4] 李衍:	
	Cart #1, 1-North Cart #2 and 2-North Cart #1).	جه. رز ا	sale ayan		ļ
1		4.4			1
	The findings included:		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	[] And [[] And [
İ	The state of the s]
	1a) An observation of the 1-North Medication			[1] 有线的形式交换管理	
	Cart #1 on 11/8/13 at 12:50 PM revealed the	4			
.]	following medications stored on the cart were "	1			
	expired:	7			
	ENPREM. S. S. S. S. S. S. S. S. S. S. S. S. S.	15		[一次] 劉永、劉明寶傳辦法司令	
	Curies d Mandiantian dt da	1.7	, ,	[一点 罐油医品牌报源]	
	Expired Medication #1:				ŀ
	An expired vial of Novolog insulin (a rapid-acting	٠,			
	insulin) labeled for Resident #113 was				
	stored on the cart. The insulin was labeled as				
	having been opened on two dates, 10/2/13 [1]			[1] [1] [1] [1] [1] [1] [1] [1] [1] [1]	
	and 10/4/13. The manufacturer's product			したため 移動師 にかか 大手遣い こうしょ	l i

	MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES		FORM	11/26/2013 APPROVED 0938-0391
	OF DEFICIENCIES (X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S A BUILDING (X3) DATE S	
	345172		The state of the s	8/2013
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE ZIP CODE	
TRIAD CA	RE AND REHABILITATION CENTER		707 NORTH ELM SYREET HIGH POINT, NC 27262	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (FACH CORRECTIVE ACTION SHOULD BE TAG CHOSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	CONDITION CONDITION (XS)
		417		
F 431	Continued From page 56		F 431	
	information indicated, "once punctured (in use),	4	朝。 如作時 (1) [4] · 从一家的复数形式。 (1)	
	vials may be stored at room temperature; use	1		
	within 28 days. "	1		
	A review of Resident #113's November 2013	.,		
	Physician Orders revealed there was a	• 5		
	current order for Novolog insulin to be used on a			
	sliding scale basis as needed (which			
	indicated the insulin was to be used only as:			
	needed and that the insulin dose used was	1		
	dependent on the resident's blood glucose level).	1		
				•
	Expired Medication # 2:	7		
	An expired vial of Lantus insulin (a long-acting)	,		
	insulin) labeled for Resident #113 was stored on	1.		
	the cart. The insulin was labeled as having been	27		
	opened on 10/2/13. The manufacturer's product	رۇپ رۇخ	## 20 ## Production	
	information indicated, " once punctured (in use);;	<u> </u>		
	vials may be stored at room temperature; use within 28 days. "		· · · · · · · · · · · · · · · · · · ·	
	Within 20 days.			
•	A review of Resident #113's November 2013			
	Physician Orders revealed there was a	ქ.		
	current order for Lantus insulin to be given once	1.	Allering to a few fields and a	
	daily.	1		
	and the state of t	٤	\$P\$ 10 10 10 10 10 10 10 10 10 10 10 10 10	
	An interview was conducted with the nurse	ts .		
	assigned to the 1-North Medication Cart #1on	13.		
	11/8/13 at 12:50 PM. During the interview, Nurse	- 6		
	#6 stated a vial of insulin should be labeled with	٠.	A STATE OF THE STA	
	the date when opened and that both the Novolog and Lantus insulin needed to be discarded 30	1 :		
	days after the date opened. Nurse #6 indicated			
	that she would need to discard the remaining	7		
	amount of the insulin and order a replacement			
	from the pharmacy.	1	The American State of the State	
	During an interview with the Director of Nursing	Y 1		
	(DON) on 11/8/13 at 4:34 PM, the DON indicated	.)		

		MEDICAID SERVICES	:: ::	N		FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(XI) PROVIDER/SUPPLIER/SUA IDEMIFICATION NUMBER:	1	(X3) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345172	-1	B. WNG		C 11/08/2013
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	(1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,
TRIAD CA	RE AND REHABILITATIO	N CENTER		**	D7 NORTH ELM STREET IGH POINT, NC 27262	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	
F 431	insulin would be store storeroom refrigerato medication cart. Once opened, it should be that the facility's polivials of insulin 30 day 1b) An observation of Cart #1 on 11/8/13 at	hat all unopened vials of ed in the medication	· · · · · · · · · · · · · · · · · · ·	F 431		
	Expired Medication # An expired vial of Lar Resident #18 was sto The insulin was label on 9/30/13. The mar product Information in (in use), vials may be room temperature; us	atus insulin labeled for ored on the cart. ed as having been opened oufacturer's adicated, "once punctured stored at se within 28 days,"	The second secon			
	Physician Orders rev current order for Land daily, Expired Medication #	us Insulin to be used once		635 635 7 7 7 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8		
	on 10/5/13. The mar information indicated, vials may be stored a use within 28 days. " A review of Resident Physician Orders rev	ed as having been opened outseturer's product (in use), troom temperature; #121's November 2013	The state of the s	N		

		ID HUMAN SERVICES MEDICAID SERVICES		FORM	: 11/26/2013 APPROVED .0938-0391
	PETICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE (COMPL	
		345172			;)8/2013
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
TRIAD CA	RE AND REHABILITATION	ON CENTER	. 61	707 NORTH ELM STREET HIGH POINT, NC 27262	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) CONPLETION DATE
			ai.		
F 431	Continued From page	a 58		F 431	
	daily.		À.		
		ducted with the nurse uth Medication Cart #1 on) }		
		interview, Nurse #4 stated			
		ard insulin after 28 days 💢	241		
		vith the Director of Nursing 4:34 PM, the DON indicated	·		:
	her expectation was	that all unopened vials 📒 👍			
	storeroom refrigerate	ed in the medication	71		
		e a vial of insulin was		4 2 2 4	
		dated. The DON specified	1		
		icy was to discard opened ;		And the second second second	
	vials of insulin 30 day	ys from the date opened.	3 417		
	1c) An observation of	of the 2-South Medication	. ,		
	Cart #1 on 11/8/13 a	t 12:10 PM revealed the 👵 🗻	: 4	The second secon	
		s stored on the cart were			
	expired:				
	Expired Medication #	14,	1.7	The state of the s	
		volog insulin labeled for	`		
		tored on the cart. The			
	ł	s having been opened on	,		
		ith a calculated expiration 🗓	نام		
		e manufacturer's product 🦠			
		, " once punctured (in use),			
		at room temperature; use	- 1		
	within 28 days. "		. [
	A review of Resident	#170's November 2013			
		ealed there was a current	1 1	[1] 27 [4] 1 [4] [4] [4] [4] [4] [4] [4] [4] [4] [4]	
	order for Novolog ins	ulin to be used on a sliding	1		
	scale basis as neede	ed.			

		ID HUMAN SERVICES MEDICAID SERVICES		FOI	ED: 11/26/2013 RM APPROVED IO, 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		re survey upleted
		345172			C 1/08/2013
NAME OF P	ROVIDER OR SUPPLIER		.12	STREET ADDRESS, CITY, STATE, ZIP CODE	
TRIAD CA	RE AND REHABILITATI	ON CENTER		707 NORTH ELM STREET HIGH POINT, NC 27262	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE OFFICIENCY)	(X5) COMPLETION DATE
F 431	Expired Medication # An expired vial of La Resident #170 was s insulin was labeled a			F 431	
	indicated, " once pu stored at room temp use within 28 days. '	nctured (in use), vials may be erature;			
	Physician Orders re- order for Lantus inst	vealed there was a current thin to be given twice daily.			- A - A - A - A - A - A - A - A - A - A
	assigned to the 2-So 11/8/13 at 12:10 PM #7 stated that insuling medication storeroo	outh Medication Cart #1 on			
	was dated and kept days. Nurse #7 indi for 28 days, the vial from the medication	on the medication cart for 28, cated that after being open and of insulin would be pulled act and put in the med room			
	thrown away.	ent back to the pharmacy or with the Director of Nursing	4		
	her expectation was insulin would be sto storeroom refrigerat	that all unopened vials that all unopened vials red in the medication or until needed on the some a vial of insulin was			
	opened, it should be that the facility 's po viels of insulin 30 da	dated. The DON specified a blicy was to discard opened bys from the date opened.			
	Storeroom on 11/7/	of the 1 North Medication 13 at 5:20 PM revealed an thromycin (an antibiotic) 200			

		ND HUMAN SERVICES				FOR	ED: 11/26/2013 MAPPROVED O, 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	ONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345172		B. WING		11	C /08/2013
NAME OF P	ROVIDER OR SUPPLIER		1		REET ADDRESS, CITY, STATE, ZIP COL	E	
TRIAD CA	RE AND REHABILITATIO	ON CENTER			NORTH ELM STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	对 经基本条	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
F 431	Continued From pag		***	F.431			
	mg/5mt suspension v	vas stored in the refrigerator. s labeled with an expiration					
	November 2013 Phy	view of Resident #199's sicien Orders revealed there					
		or azithromycin to be given? by mouth once weekly.					
		resent during the Storeroom	1			•	
	Nurse #13 on 11/7/1:	rview was conducted with 3 at 5:20 PM. At that time, expired azithromycin would	11	ſ			
	need to be discarded medication storeroor	I. Nurse #13 indicated the income were routinely checked by	4			in Notae	
	expectation that all e	at coordinators and it was her expired medications would it is returned to the pharmacy."	3				
;		of the 1-North Medication				· · · · · · · · · · · · · · · · · · ·	
	unopened vial of Hui	t 1:20 PM revealed an malog insulin (a rapid-acting					
	the cart. The insulin	esident #152 was stored on was dispensed from the 13. The vial was not labeled	1			: - 	
	with the date it was proom temperature.	out on cart and stored at According to the product					
	under refrigeration u	ned vials may be stored intil the manufacturer is room temperature for 28		*			
	days. A review of Re 2013 Physician Orde	sident #152's November ers revealed there was a					
	current order for Hur sliding scale basis.	nalog insulin to be used on a					
	L	nducted with the nurse with Medication Cart #2 on					
	11/8/13 at 1:20 PM. #10 stated that unop	During the interview, Nurse ened insulin should be kept til needed and not stored at he				· .	

TATEMENT (F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	. 1
	•	 (1) (2) (2) (2) (2) (2) (2) (3) 		C
		345172	B. WING	11/08/2013
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	•
TRIAD CA	RE AND REHABILITATION	ON CENTER	707 NORTH ELM STREET	a a
			HIGH POINT, NC 27282	· · · · · · · · · · · · · · · · · · ·
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRE- PREFIX (EACH CORRECTIVE ACTION SHO	
PREFIX		LSC IDENTIFYING INFORMATION)	TAG CROSS-REFERENCED TO THE APP	
			DEFICIENCY)	
		在一个"人才会的教学"。		
F 431	Continued From pag	e 61	F 431	
	room temperature or	the cart.		
			· 一个,这样的一点的一点,这个程度的不]
	During an interview v	vith the Director of Nursing		
		4:34 PM, the DON indicated		
	her expectation was	that all unopened vials		1
	insulin would be stor	ed in the medication		
		or until needed on the		
		facility was unable to. 🚶 🛒 🔅		
		about how long an unopened		
		en in the unrefrigerated 🦠 🐈 🥏		
٠.		e vial would not be dated 🚞 🧢 🥫		
		The DON specified that the		
		o discard opened vials of		
	insulin 30 days from	the date opened.		
	Ohl An abaanattaa a	Ethn O North Mediculian Cost		
		of the 2-North Medication Cart		
		red on the medication cart		
		as to when they were moved		
	to storage at room te			
	Medication # 1 Store	d at Room Temperature:	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	
		Lantus insulin was stored on		
:		was dispensed from the		
	pharmacy on 11/2/13	3.1 The vial was not labeled . 1		
	with the date it was p	out on cart and stored at		
		According to the product 👍 🛒		
		ned vials may be stored		
		ntil the manufacturers		
		room temperature for 28,		•
	days.			
		d at Room Temperature	$\frac{1}{2} \left(\frac{1}{2} + 1$	
		Levemir insulin was stored		•
		ulin was dispensed from the		
	, ,	13. The vial was not labeled tout on cart and stored at	Mark 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
		According to the product		1
		ned vials may be stored:		

		ID HUMAN SERVICES MEDICAID SERVICES	;			FO	ED: 11/26/2013 RM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE	ECONSTRUCTION	(X3) DA	<u>(O. 0938-0391</u> re survey xpleteo
		345172		B. WING			C 1/08/2013
NAME OF P	ROVIDER OR SUPPLIER	A CONTRACTOR OF THE PARTY OF TH	9 : 9 !:		STREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
TRIAD CA	RE AND REHABILITATIO	ON CENTER	3. : 4. :	- 1	707 NORTH ELM STREET HIGH POINT, NG 27262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PREFIX TAG	PROMDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From page under refrigeration un	til the manufacturer 's	100	F.431			
	expiration date or at n days. An interview was cond	oom temperature for 42				•	
	assigned to the 2-Nor 11/8/13 at 12:23 PM, #9 stated that unopen kept in the refrigerator stored on the cart. He	th Madication Cart #1 on During the interview, Nurse ad insulin vial should be until needed and not noted that once insulin is rator it is good for 28 days.					
17. H	During an interview wi (DON) on 11/8/13 at 4 her expectation was It insulin would be stored	th the Director of Nursing 34 PM, the DON indicated nat all unopened vials					
	storeroom refrigerator medication cart. The f provide information ab vial of insulin had beer medication cart as the until it was opened. Ti	until needed on the	The second secon	4 4 4 4			
	insulin 30 days from th	e date opened. the 2-South Medication 2:10 PM revealed an		N generalis		·	
	Resident #170 was sto insulin was dispensed 9/25/13/13. The vial was put on cart	red on the carl. The from the pharmacy on vas not labeled with the and stored at room.					
	expiration date or at ro	ed vials may be stored I the manufacturer's 11 4 born temperature for 28 dent #170's November					Transmission of the state of th
		nevealed thata was a	2]]

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	7		<u>中一方向行为</u> 自己特集的方面。	OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	7	(X2) MULTIPL	E.CONSTRUCȚION CONSTRUCȚION	(X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		A BUILDING		COMPLETED		
						C		
		345172	1	B. WING		11/08/2013		
NAME OF P	ROVIDER OR SUPPLIER		13:		STREET ADDRESS, CITY, STATE, ZIP CODE			
TOLLO	RE AND REHABILITATIO	WI CHAPTED	12.		707 NORTH ELM STREET			
ININD CA	IKE MIND KEMMBICHMIK	AN CENTER	18		HIGH POINT, NC 27262			
(X4) ID		ATEMENT OF DEFICIENCIES	- 1	ID.	PROVIDER'S PLAN OF CORRECTION			
PŘEFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	22	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR			
TAG	ACOUNTON ON	TO DETERM THE IN CHARACTER ST.	\$	TAG	DEFICIENCY)	V/A114		
		4 () () ()	 .	 				
F 431	Continued From page	63		F 43				
	sliding scale basis as		1	F-43	1. 网络双维鲁克克			
	Suching Scale Dasis as	needed.	25		100 100			
	An interview was con	ducted with the nurse						
		Ith Medication Cart #1 on	1					
		During the interview, Nurse	77	"				
	#7 stated that insulin							
		refrigerator until needed on	-71		• 127			
		at of insulin was opened, it i	43					
		in the medication cart for 28				.		
		ated that after being open	1					
		of insulin would be pulled san and put in the med room.	.:					
		is and put in the med room,						
	thrown away.	A DOOK to the phalificacy of		100 mg 1	A Martin Control of the Control	į.		
	, , , , , , , , , , , , , , , , , , , ,	1、 14 Proceedings (1)	7.	la talent in				
		rith the Director of Nursing 🐑	- 1					
		4:34 PM, the DON indicated		1	事 1 人名英格兰斯 \$P\$ \$P\$ \$P\$ \$P\$			
		hat all unopened vials 📜 🚯	24		国际的自己的自己的			
	insulin would be store		fi (1	4 4 7	■ 異種軟件 報復責任	***************************************		
	storeroom refrigerato				事子中的交流器 医高克雷斯基	9		
	medication cart. The	facility was unable to bout how long an unopened	:11					
• •		en in the unrefrigerated						
		≥ vial would not be dated						
		The DON specified that the	11.					
		to discard opened vials of	: .			1		
	insulin 30 days from t	he date opened. 💮 🚈 🗓						
	l		* 1			<u> </u>		
		of the 1-North Medication	- 4					
		12:50 PM revealed an 13	6	M. 61.5				
		g/50mcg inhaler (a dry for asthma or chronic						
		ase) labeled for Resident	21:	1 .	本一个的证明的注意			
		to when it had been opened		.,				
		e foll pouch. The inhaler's						
		were 51 doses remaining in	11		The state of the s			
	the inhaler. Supplem	ental labeling from the	33					
		noted the Advair Diskus 🗼	21					
	inhaler "Expires 1 m	onth after opening:" :The 🖖	***			1		

		D HUMAN SERVICES					FOR	D: 11/26/2013 M APPROVED D: 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA : IDENTIFICATION NUMBER:	741	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	A market and a mar	(X3) DATE	SURVEY PLETED
	-	345172	-61.°	B. WING				C /08/2013
NAME OF P	ROVIDER OR SUPPLIER		ΑÌ	s	TREET ADDRESS, CITY,	STATE, ZIP CODE		· · · · · · · · · · · · · · · · · · ·
TRIAD CA	RE AND REHABILITATION	N CENTER			07 NORTH ELM STREE IGH POINT, NC: 2726	E E		
(X4) ID PREFIX YAG	(EACH DEFICIENC	atement of deficiencies Y must be preceded by full sc identifying information)	15	ID PREFIX ,TAG	(EACH CORR CROSS-REFER	YS PLAN OF CORRECTIC RECTIVE ACTION SHOULD RENCED TO THE APPROP DEFICIENCY) 8E	(AS) COMPLETION DATE
F 431	Continued From page	e 64 was dispensed from the	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	F 431			-	
	pharmacy on 9/14/13 November Physician	A review of Resident #35's Orders revealed there was a air Diskus inhaler 100/50						
	mcg/dose to be given During an interview w	twice daily.						
	Diskus inhaler could taken, regardless of t	stated she thought an Advair be used until all doses were he date the inhaler was						
4, 5	indicated she was no needed to be dated u	packaging. Nurse #6 * * t aware that the inhalers pon opening or that the						
	expiration date of the adjusted once the infoil packaging.	inhaler would need to be aler was removed from the				And the second s		
	(DON) on 11/8/13 at the facility 's policy w	vith the Director of Nursing 4:34 PM, the DON indicated has to date anything that is						
		vair Diskus inhalers. She Siskus inhaler would have a conce opened.	**	N. S. A.		And the second s		
	#2 revealed the follow stored on the cart wit	the 1-North Medication Cart ving medications were nout being labeled with a Vor expiration date;	***************************************		45 p 45 p.			
	Expiration Date:	1 without a Labeled 4.4.4.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1				A CONTRACTOR OF THE CONTRACTOR		
	made during medicat administration on 11/ opened, undated vial	ion pass 7/13 at 9:00 AM revealed an of Novolog insulin labeled		M	an ing			
	noted the vial of insul the pharmacy on 8/29	stored on the cart. It was in had been dispensed from 0/13. A review of Residenti Physician Orders revealed						

		ID HUMAN SERVICES MEDICAID SERVICES		4 4 4 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4			FOR	D: 11/26/2013 M APPROVED D: 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		V BRITO		CONSTRUCTION			E SURVEY PLETED
		345172	i	B. WING	=			11	C /08/2013
NAME OF P	ROVIDER OR SUPPLIER	1000年1日建筑机会。	j.	a , %		TREET ADDRESS, CIT	ニューショル 多りごう		
TRIAD CA	RE AND REHABILITATION	N CENTER	14: 14:			07 NORTH ELM STRE HIGH POINT, NC 27	5 × 4 V		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Atement of Deficiencies (1) (1) (2) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4		PREFI TAG	×	(EACH CO	DER'S PLAN OF CORRECTIVE ACTION SHO ERENCED TO THE APPL DEFICIENCY)	ÁÍD BÉ	(XS) COMPLETION DATE
			7.5			1. Apr. 18 2. 14.		*	
F 431	Continued From page	3 65	N.,	F		1 12			
	there was a current o	rder for Novolog insulin to	į.	1		1 44			
		ns a scheduled medication				iz :	4. 4.		
	and used on a sliding	scale basis as needed.	ζ,						
	Madication # 2 Store	d without a Resident 's	23						
	Name or Labeled Ex					V 38			
	1	of the 1-North Medication	1			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
	Cart #2 made on 11/6								
		undated Advair Diskus	1	-					
		tored on the cart. The nhaler was not labeled with							
		ame or date as to when it							-
	had been opened.			4					
	An interview was con	ducted with the nurse	5 t 5 t 6 t			1	n n n		
		rth Medication Cart #2 on 🕛	. 31 14						
		During the interview, Nurses				1 3 40			
		should have been labeled "							
:		pened and that Novolog () discarded 30 days after the	4		٠.		1.6		
		#10 indicated that since the	::	.,			- 1		
		dated when opened, she				1 10			
		d the remaining amount and	11				1	•	
	order another vial fro	m the phannacy.			,	\$1.7	1. 1. 2. 1. 2. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.		
	A follow-un intention	was conducted with Nurse							
	1	20 PM. During the interview,	:):	{ · · · · · · · · · · · ·					
		sample Advair Diskus 🦙 🕆			1.				
		oeen labeled with the 🥍 💆 🔭		1 1	1.00				
		date opened. She indicated	.4						-
	the inhaler would nee	ed to be discarded.	:						
	During as islandous	vith the Director of Nursing	4.	1.					
		4:34 PM, the DON indicated	11			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1.1		
		that all unopened vials	1			130 AF			
		ed in the medication		- 11			198 教师		
		or until needed on the	-	1		1			
		ce a vial of insulin was	24		£.	No. 1			

			 		Spiliters, Allocionia
DEPART	MENT OF HEALTH AND HUMAN SERVICES				PRINTED: 11/26/2013 FORM APPROVED
	1		1.		
	RS FOR MEDICARE & MEDICAID SERVICES		Υ		OMB NO. 0938-0391
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLÍA	- 11	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
I MU FOR U	F CORRECTION IDENTIFICATION NUMBER:		A BUILDING		OOMPAGIED
		çi.			C
	345172		B. WING	2.1 (2) 排程性2种 异型 文献 養 [2] (3)	11/08/2013
NAME OF P	PROVIDER OR SUPPLIER	21		STREET ADDRESS, CITY, STATE, ZIP CODE	
'' '''		1		707 NORTH ELM STREET	
TRIAD CA	ARE AND REHABILITATION CENTER	4		(1) 11 (1) 12 (1) 12 (1) 12 (1) 12 (1) 13 (1) 14 (1) 14 (1) 14 (1) 14 (1) 14 (1) 14 (1) 14 (1) 14 (1) 14 (1) 14	
L		13		HIGH POINT, NO 27262	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	1	: Gl	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL / TREGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD E	
TAG	REGOLATORY OF ESC IDENTIFIED BY CAMOUNT		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE .
		- 44	The second		Ī
F 431	Continued From page 66		F 431		
	that the facility's policy was to discard opened			中一个新的性质的重要点。	
	vials of insulin 30 days from the date opened.	1		· 《海·克··································	
	The DON further stated the facility's policy was to	×		1. 1. 位以如《李晓·李集诗》。	
	date anything that is opened, including Advair			本の変配を主義の整整をより、	į į
	Diskus inhalers. She indicated the Advair Diskus	11			
	inhaler would have a 30-day expiration date once				
	I to the second				
	opened.		.1		
	4-1 4-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	F.			1
	40) An observation of the 2-North Medication :	- 1			[
	Cart #1 on 11/8/13 at 12:23 PM revealed a bottle				
1.1	of [brand name] nutritional supplement was being	1.			
	stored on the medication cart. The nutritional		*		
	supplement was not labeled with either a 3 50000	4	4		
	resident's name or expiration date.	1		上 小铁 医牙 钱载。	
			W >	A Maria Control of the Control of th	
	An interview was conducted with Nurse #9 on 🔗	÷,			
	11/8/13 at 12:23 PM. During the interview, Nurse				
	#9 stated the bottle of nutritional supplement was	* 1		1 日本 1961年 1961年 1961年	
	provided by the family of Resident #122 and				
	approved by his physician. Upon review of the				
	bottle, Nurse #9 confirmed there was not an.		7.4 1.3		
•: •	expiration date on the bottle and indicated it	•		10000000000000000000000000000000000000	
- 12 t	should have been labeled with both the resident's	41	44¢4		
, ,	name and an expiration date from the				
	manufacturer or pharmacy. The nurse indicated	福門		10 日本 新原金属	
	that since there was no expiration date on the			A 10	
	bottle, it would need to be discarded and	11			
	replaced.	- 1	9	F 12 13 13 13 13 13 13 13 13 13 13 13 13 13	
E 444		53	- 4.4		
F 441	483.85 INFECTION CONTROL, PREVENT	;	F 441	F441	[
\$\$=D	SPREAD, LINENS	- 4			
	The feelility and entablish and annintative "". W		" .	1. Resident #170 had the glucose	
	The facility must establish and maintain an			meter disinfected prior to completi	ne
	Infection Control Program designed to provide a	- 4		the blood glucose tests.	
	safe, sanitary and comfortable environment and			Anna and Brahanc (minn)	
	to help prevent the development and transmission	3	4		
1	of disease and infection.		*.		
			16	1、李操《医科·特殊的》(
Į	(a) Infection Control Program	' !		· 阿特·西班	
1	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1			· · · · · · · · · · · · · · · · · · ·	1

	7 1 37 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1,	<u> </u>	and the second of the first second	PRINTED:	11/26/2013
	MENT OF HEALTH AND HUMAN SERVICES 🦑	1 2		医二氯磺胺二基酚基氯基酚	FORM.	APPROVED
CENTER	S FOR MEDICARE & MEDICAID SERVICES	`.t	ica di 🗼		<u>OMB NO.</u>	0938-0391
STATEMENT (OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		(X2) MULTIPLE A. BUILDING_	CONSTRUCTION,	(X3) DATE S COMPLI	ETED
	345172	1	8. WING	· 多种品 () (4.4)	C 44 0	
			1	World annual or Army Army and Army	11/0/	8/2013
	ROVIDER OR SUPPLIER RE AND REHABILITATION CENTER	l.,	7	YREET ADDRESS, CITY, STAYE) ZIP CODE 07 NORTH ELM STREET HIGH POINT, NC 27262		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX /	PROVIDERS PLÂN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) CONDLETION DATE
			1,2 1,1 1,1	2. Nurse #3 was in-serviced		
F 441	Continued From page 67		F 441			
	The facility must establish an Infection Control			procedure of disinfecting the	1	
	Program under which it			blood glucometer, wiping with a	-	
	(1) Investigates, controls, and prevents infections					
	in the facility;	1.1	4	Clorox wipe prior to use, after use a		
	(2) Decides what procedures, such as isolation,	44.5	4 4 4 4 4	waiting 2 minutes to dry, with repea		!
	should be applied to an individual resident; and	- 61	1	demonstration. Licensed nurses will		
	(3) Maintains a record of incidents and corrective	,		be in-serviced on the disinfecting of		
	actions related to infections.	~;		the blood glucometer by SDC by		
		.:		12/06/13.	ĺ	
	(b) Preventing Spread of Infection	1.				
	(1) When the Infection Control Program 4					
	determines that a resident needs isolation to	1		3. New nurses hired will be oriented	j	
	prevent the spread of infection, the facility must isolate the resident.			and checked off prior to starting the	ir	
	(2) The facility must prohibit employees with a	24	:	medication pass. Wiping the blood		
	communicable disease or infected skin lesions	- 1 - 1		glucometer prior to use, after use an	ıd	
i	from direct contact with residents or their food, if		51.5	then wait 2 minutes to dry. Staff	•	
	direct contact will transmit the disease.		9	Development Coordinator will obser	1/6	
	(3) The facility must require staff to wash their			nurses on medication process and	**	
#*	hands after each direct resident contact for which	1		check off weekly for 2 months, then]	i
	hand washing is indicated by accepted	34				12/00/42
	professional practice.			bi-weekly'	1,	12/06/13
	11 11 11 11 11 11 11 11 11 11 11 11 11	13	"	for 1 month.		
•	(c) Linens		1 4			
	Personnel must handle, store, process and	10.1		4. The DNS will be responsible		
	transport linens so as to prevent the spread of			For the process and bring findings		
	infection.	, .	l e	to the monthly PI meeting for the ne	xt	
	10 Maria			3 months.		1
}		٠,			1	İ
Ì	This REQUIREMENT is not met as evidenced			10. 数据文献 医神经素 整理 10. 数据 第二章 整理		i
	by:	5	9 3			į
	Based on observation, record review, and staff.			可能性性對對導致的	ļ	j
ļ	interviews, the facility failed to clean and disinfect		**	學職編集課題		
	a shared glucometer (glucose meter used to			- 大規模・経済・安保・基本が、カラー - 大規模・経済・基準を基準によっている。		1
	measure a resident's blood augar level) for 1 of 2					
	residents observed (Resident #170) receiving	1	1			}
	blood alucase maniforing					
:	The state of the s	3.1	M 8 4 1	10、1、1部2000年6月春旬日]

		D HUMAN SERVICES MEDICAID SERVICES				PRINTED; 11/28/2013 FORM APPROVED OMB NO. 0938-0391
	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:		(X2) MULTIPLE A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345172		B. WNG		C 11/08/2013
	ROMDER OR SUPPLIER RE AND REHABILITATIO	N CENTER	÷ 1	7	STREET ADDRESS, CITY, STATE, ZIP CODE 767 NORTH ELM STREET HIGH POINT, NO 27262	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1 () () () () () () () () () (ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERÊNCED TO THE APPROPRIA (DEFICIENCY)	
F 441	Continued From page The findings included		- 多种人	F 441		
	(CDC) guidelines, she should be cleaned an patient use. The CDC guidance provided by					
	appropriate products and disinfaction of blo disinfection solvent of	for manufacturers regarding and procedures for cleaning to glucose meters. The tosen should be effective modeficiency virus (HIV),				
	Hepatitis C; and Hepa recommended that he the manufacturers of at their facilities to de	atitis B virus: It is ealthcere personnel consult blood glucose meters in use termine what products,		30		
	compatible with their	pecified by the FDA, are meter prior to using any EPA ction Agency)-registered action purposes.				,
	dated 6/1/96 and revi reviewed. This proce	re entitled, Glucose Meter sed on 10/1/12 was dure indicated, " Disinfect use " using an " appropriate	The state of the s			·
	manufacturer 's webs customers dated 12/1 issue of cleaning and	brand name) glucose meter alte revealed a letter to 9/12 that addressed the disinfecting guidelines for he guidelines provided in following:	· · · · · · · · · · · · · · · · · · ·			
	lint-free cloth damper "Disinfecting Guidelin clean the meter surfa	Use a moist (NOT WET) led with a mild detergent, " es: To disinfect your meter, ce with [brand name] ith Bleach or [brand name]	The state of the s			

		ID HUMAN SERVICES MEDICAID SERVICES				APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	OX21 MULTIPL	E CONSTRUCTION	(X3) DATE	. 0938-0391 SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			ETED
	4					;
		345172	B. WNG		11/0	08/2013
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		•
TRIAD CA	ARE AND REHABILITATION	IN CENTER		707 NORTH ELM STREET		
	 			HIGH POINT, NC 27282		
(X4) ID PREFIX	SUMMARY ST.	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 3	ID PREFIX	PROVIDERS PLAN OF CORRECTIVE ACTION SHOUL	ON	(XS) COMPLETION
TAG		SCIDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROX		DATE
				DEFICIENCY)		
				十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二	,	
F 441			F 44			:
	Bleach Germicidal W	pes."				
ı	The hun disinfectors					
ı	the manufacturer wer	products recommended by				
		the criteria specified by the				
	FDA. Additional note			a 1		
		d other formules containing				
		were in the process of		▶ 人名德格尔克特勒尔 (5)		
		inufacturer also indicated, "				
		d, blood glucose meters d disinfected after every				
	use."	o distincted after every				
		2000年期中國原東	4			
	During a medication a		1 1 1 1 1 1 1 1 1			
	observation on 11/7/1	3 at 4:16 PM, Nurse #3	,		1	
	used a [brand name]	glucometer to obtain a blood		N N		
		esident #31. After the	***			
	on ton of the medicati	e nurse set the glucometer on cart. Nurse #3 was				
	continually observed	during the medication				
	administration pass a	s this glucometer remained.				
	on top of the medicati	on cart. At 4:20 PM, Nurse		1 人名英格兰斯勒特		
	#3 was observed as a	he used a [brand name] 🦠 🐪 .				
	hand wipe to clean the	shared glucose meter in	1 1	1、1、40mm(2000)。		
		a blood sample from the sample from the sample from the sample for hand the sample for hand the sample for hand the sample for hand the sample from the sample				
1.3		not an EPA-registered				
		e then gathered the blood	,,			
	glucose monitoring su	pplies and the glucometer				
	which had been previ	busly used for Resident #31.			-	
	Nurse #3 knocked on	Resident #170 's door and			İ	
	entered her room. At	this time, a request was step out of the resident's				
	room When Induse to	s made as to whether				
		illable for use for				
	disinfecting a shared of	lucometer between	1			
	residents. Nurse #3 s	tated there was one other			ļ	
		a container of (brand name)]	
		des from her medication			{	
ORM CM\$-256	7(02-99) Previous Versions Obsc	ilete Event ID: 50MJ	11 F	city ID: 923288 / If can	invation sheet	Page 70 of 71
			· * * * * * * * * * * * * * * * * * * *			
			,}			

		#-1	PRINTED: 11/26/20
	MENT OF HEALTH AND HUMAN SERVICES	- 13: 	FORM APPROVI
CENTER	S FOR MEDICARE & MEDICAID SERVICES 1 - 4 -		OMB NO. 0938-03
	OF DEFICIENCIES (X1) PROVIDENSUPPLIENCLÍA "		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY
AND PLAN OF	CORRECTION IDENTIFICATION NUMBER:	٠,	A BUILDING COMPLETED
			\mathbf{c}
	345172	1	8, WNG 11/08/2013
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE
			707 NORTH ELM STREET
TRIAD CA	RE AND REHABILITATION CENTER	* 25g	HIGH POINT, NG 27262
	20 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -		Spage of the first free free free free free free free fre
(X4) IĎ PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL)	3	PROVIDER'S PLAN OF CORRECTION (XS) PREFIX (EACH CORRECTIVE ACTION SHOULD BE GOUPLETIC
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	19	TAG CROSS-REFERENCED TO THE APPROPRIATE DATE
	The state of the s	17	DEFICIENCY).
	为19.10 EXAMPLE.	:	3
F 441	Continued From page 70		5 F441 - 1 基本等等 (基本)
	cart. At that time, Nurse #3 Indicated she did not	- 3	
	initially use these wipes to clean the glucometer		
	because they could not be used on hands. Nurse	- ;	到一点,1、多点。 在食物 (control)
	#3 then used one of the [brand name] Bleach	ä	
	Germicidal Wipes to disinfect the shared		
	glucometer prior to completing a blood glucose		
	test for Resident #170. The [brand name] Bleach	[4] (4)	
	Germicidal Wipes were an EPA-registered 3 3		
	disinfectant meeting the criteria specified by the		
	FDA.		
. : :			
•	An interview was conducted with the Director of	4	
	Nursing (DON) on 11/7/13 at 4:36 PM regarding	11	制 (1000 m) (1000 m) (1000 m) (1000 m)
	the cleaning and disinfection of shared	:1	1
	glucometers. The DON indicated her expectation		
	was for the shared glucometer to be disinfected	× 1	
	before and after each of the resident's blood glucose tests. She indicated the glucometers		
	were wiped with a bleach cleaning wipe and		
	allowed to air dry for at least-two minutes prior to	•	
	re-use. When asked if it was acceptable to use a		
	hand wipe (labeled for hand hygiene use) to clean	4	
	the glucose meter, the DON indicated it was not	- :	
	and stated, "It's supposed to be bleach." She	1	
	further indicated the nurse observed cleaning a 🐣	11	到了"你们来?"陈敖的高耸的 没 拿着这些人。
	glucose meter with a hand wipe would need to be	4.	
	in-serviced to insure the correct wipes were used	4	
	to disinfect a shared glucometer.		- 1
	o distinct a strated glacofficter.	* 3	
	1975年 阿拉克斯里		
	Service Services (Services)	,	
ĺ		•	
		4	
			制。在1914年1月1日 · 1914年1月1日 · 1914年1日
		. 1	· 1
		• a	
	and the second of the second o	- 1	
1	La contraction of the contractio		

This STANDARD is not met as evidenced by:

A, Based on observation on 11/27/2013 the

11 20 1

related to requirements of door latches.

4. The Maintenance Director or designee will audit all latching doors in the facility weekly for 1 month and monthly for 2 months.

Results of the audit will be reported during the monthly Performance Improvement meeting

12/20/13 (X6) DATE

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

11/2-

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

FORM CM5-2567(02-99) Previous Versions Obsolete

Event ID: 50MJ21

Facility ID: 923288

for 3 months.

If continuation sheet Page 1 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/02/2013 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARD	A WILDIONID OLIVIOUS	/V=1 14711	T (E)1 E	E CONSTRUCTION	(X3) DAT	ESURVEY
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			11 - MAIN BUILDING 01	COM	PLETED
ĺ		345172	B. WING			11/27/2013	
TRIAD C	/EACH DEFICIENC	TEMENT OF DEFICIENCIES	ID PREF	70 HI X	REET ADDRESS, CITY, STATE, ZIP CODE 17 NORTH ELM STREET IGH POINT, NC 27262 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES	BE	(X5) COMPLETION DATE
PRÉFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)			
K 018 K 029 SS=D	room near room11 42 CFr r83.70 (a) NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 prothe approved autoroption is used, the other spaces by she doors. Doors are sheld-applied protect.	atch when closed 22,141 and the clean linen 3. AFETY CODE STANDARD construction (with ½ hour an approved automatic fire im in accordance with 8.4.1 atects hazardous areas. When matic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or ative plates that do not exceed bottom of the door are			K 029 1. The doors to the soiled side to the la room and the second floor soiled linen room 227 were repaired by the Mainten Director on 12/10/13. 2. An audit was completed by the Maintenance Director on 12/10/13 relacorridor doors and latching with repairs as needed. Monitoring of doors will be the Preventative Maintenance Program TELS System.	near nance nance sted to s made put on	
K 038 SS≂D	A, The door to the failed to close and B, Second floor so to close and latch. 42 CFR 483.70 (a) NFPA 101 LIFE SA Exit access is arra accessible at all tin 7.1. 19.2.1	iled linen near room 227 falled		38 8	3. The Maintenance Director was educated Kevin Wright, Regional Property Mana 12/10/13 related to the requirements of self closing and latching. 4. The Maintenance Director or designated the facility was for 1 month and monthly for 2 months. Results of the audit will be reported dumonthly Performance Improvement me for 3 months.	ager on doors ee will eekly ring the	12/20/13

FORM CMS-2667(02-98) Previous Versions Obsolete

Eveni ID:5QMJ21

Facility 1D; 923288

If continuation sheet Page 2 of 4

STATEMENT OF DEFICIENCES INT PROVIDER ON BUPPLIER A SUILLING OF NAME OF PROVIDER ON SUPPLIER TRIAD CARE AND REHABILITATION CENTER TRIAD CARE AND REHABILITATION CENTER TRIAD CARE AND REHABILITATION CENTER SUMMARY STATES AND COMMERCE OF DESICIONATION PROPERTY. TAG TRIAD CARE AND REHABILITATION CENTER TRIAD CARE AND REHABILITATION CENTER SUMMARY STATES AND COMMERCE OF DESICIONATION PROPERTY. TAG TRIAD CARE AND REHABILITATION CENTER TRIAD CARE AND REHABILITATION CENTER SUMMARY STATES AND COMMERCE OF DESICIONATION PROPERTY. TAG TRIAD CARE AND REHABILITATION CENTER TRIAD CARE AND REHABILITATION OF PROPERTY AND COMMERCE A			(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPL	E CONSTRUCTION		E SURVEY
MANE OF PROVIDER OR SUPPLIER TRIAD CARE AND REHABILITATION CENTER X49 ID REGULATORY OR LSC IDENTIFYING INFORMATION PREPIX (ACAD RESTRICT SHOULD BE (SACH DESTRICTION SHOULD BE (SACH DESTRICTI							COM	PLETED
MANE OF PROVIDER OR SUPPLIER TRIAD CARE AND REHABILITATION CENTER X49 ID REGULATORY OR LSC IDENTIFYING INFORMATION PREPIX (ACAD RESTRICT SHOULD BE (SACH DESTRICTION SHOULD BE (SACH DESTRICTI								
TRIAD CARE AND REHABILITATION CENTER TOTAL CARE AND REHABILITATION CENTER THIGH POINT, NC 27262			345172	B. WING			11 <i>]:</i>	27/2013
TRIAD CARE AND REHABILITATION CENTER (X4) ID (C4) ID (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSc IDENTIFYING INFORMATION) K 038 Continued From page 2 Based on observation on 11/27/2013 there were (3) three rooms on the baock that has hasp and locks A, Main storage room, Boiler room and the small storage room across from the Main Storage room. B. Staff did not know about the master door release switch at the nurses station. C. The med, storage room at the lounge requires more than one motion of the hard to exit the room. D. There is no master switch for the door release at Nurses Station # 2. North. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm systems is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided, Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	NAME OF I	PROVIDER OR SUPPLIER			\$	TREET ADDRESS, CITY, STATE, ZIP CODE		
CALLO PRETEX TAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE) REGULATORY OR LSc IDENTIFYING INFORMATION) K 038 Continued From page 2 Based on observation on 11/1/2/7/2013 there were (3) three rooms on the baock that has hasp and locks A. Main storage room , Boiler room and the small storage room across from the Main Storage room. B. Slaff did not know about the master door release switch at the nurses station. C. The med. storage room at the lounge requires more than one motion of the hand to exit the room. D. There is no master switch for the door release at Nurses Station # 2 North. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm code, to provided that manual pull stations are within 200 feet of nurse's stations. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintalined in accordance with NFPA 72 and records of maintenance are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintalined in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	WELL D. C.	ANT AND DEMARKS	ATION CENTED					*
K 036 Continued From page 2 Based on observation on 11/27/2013 there were (3) three rooms on the back that has hasp and locks A, Main storage room, Boiler room and the small storage room across from the Main Storage room. B. Staff did not know about the master door release switch at the nurses station. C. The med. storage room at the lounge requires more than one motion of the hand to exit the room. D. There is no master switch for the door release at Nurses Station # 2 North. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NPPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	TRIAD C	AKE AND KENADILI I	ATION CENTER		Н	IIGH POINT, NC 27262		
Based on observation on 11/27/2013 there were (3) three rooms on the back that has hasp and locks A. Main storage room, Boiler room and the small storage room across from the Main Storage room. B. Staff did not know about the master door release switch at the nurses station. C. The med. storage room at the lounge requires more than one motion of the hand to exit the room. D. There is no master switch for the door release at Nurses Station # 2 North. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 1) The three rooms identified as the main storage room in the back that had the hasp and locks were removed on 11/27/13 by the Maintenance Assistant. The remaining hardware was removed on 11/27/13 by the Maintenance Assistant. The remaining hardware was removed on 11/27/13 by the Maintenance Assistant. The remaining hardware was removed on 11/27/13 by the Maintenance Assistant emoved the deadbolt lock and covered with metal plate on the med storage room (central supply) on 12/09/13. Protection Services, Inc. Installed a master switch for the door release at Nurses Station #2. An audit of all doors with exit access was completed by Maintenance Assistant; on 12/10/13 to ensure that exits are readily accessible at all times. 3) SDC re-educated all employees on 11/27/13 to ensure that exits ar	PREFIX	(FACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	38	
	K 038 K 051	Continued From particles Based on observations of locks A, Main storage root storage room across room. B. Staff did not know release switch at the C. The med. storage more than one motivore. D. There is no mas at Nurses Station #42 CFR 483.70 (a) NFPA 101 LIFE SA A fire alarm system devices or equipment NFPA 72, National effective warning of Activation of the communal fire alarm in extinguishing system that manual pull stanurse's stations. Popath of egress, Eletests are available, power is provided, maintained in accorrecords of maintenations are provided and system to an approvided maintained and approvided	ge 2 tion on11/27/2013 there were the baock that has hasp and om, Boiler room and the small as from the Main Storage w about the master door e nurses station. e room at the lounge requires ion of the hand to exit the ter switch for the door release 2 North. FETY CODE STANDARD with approved components, ent is installed according to Fire Alarm Code, to provide fire in any part of the building, mplete fire alarm system is by nitiation, automatic detection or m operation. Pull stations in eas may be omitted provided ations are within 200 feet of ull stations are located in the ctronic or written records of A reliable second source of Fire alarm systems are dance with NFPA 72 and ence are kept readily available, nunciation of the fire alarm		95	1.) The three rooms identified as the masterage room, boiler room and the smal storage room in the back that had the had locks were removed. The locks were removed. The locks were removed. The locks were removed in 1/27/13 by the Maintenance Assist: The remaining hardware was removed in 12/06/13 by the Maintenance Director. Development Coordinator (SDC) began servicing all staff on the master door (Nock) release switches on 11/27/13. The Maintenance Assistant removed the dealock and covered with metal plate on the storage room (central supply) on 12/09/Protection Services, Inc. installed a masswitch for the door release at Nurses Staff 2 North on 12/10/13. 2.) An audit of all doors with exit access completed by Maintenance Assistant; of 12/10/13 to ensure that exits are readily accessible at all times. 3.) SDC re-educated all employees on 11/27/13 related to the master door (MalLock) release switches. 4.) Maintenance Director/SDC or design will complete interviews with random employee sample weekly for four weeks monthly for two months and during orientation for all new hire to ensure understanding and proper usage of mast switch for the door release. Results of the interviews will be reported during the mister to the control of the interviews will be reported during the mister to the control of the door release. Results of the interviews will be reported during the mister to the control of the door release.	l asp and moved ant. on Staff in fin-dag e addolt e med, '13. ster ation s was a g	42/20/42
						months.		12/20/13

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01 - MAIN BUILDING 01					
		345172	B WING		11/27/2013			
-	PROVIDER OR SUPPLIER ARE AND REHABILIT	TATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET HIGH POINT, NC 27262					
(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 CROSS-REFERENCED TO THE APPROPRIED TO THE	OULD BE COMPLETION			
K 051	This STANDARD is not met as evidenced by: A. The phone connection for the FACP could not be tested as they could be located. 42 CFR 483.70 (a)		K 08	K051 1.) Protection Systems, Inc. was contacted and came out to the facility to inspect the Fire Alarm Control Panel (FACP) on 12/12/13. Protection Systems informed the Maintenance Director that an independent phone line needed to be installed to have the proper connection for the FACP. 2.) The Maintenance Director contacted				
K 069 SS=D	Cooking facilities ar with 9,2.3. 19.3.2 This STANDARD is A. Based on observ	re protected in accordance 1.6, NFPA 96 s not met as evidenced by: vation on 11/27/2013 the nsul for the range hood was		Genesis HealthCare IT department to install an independent phone line for the FACP on 12/12/13. North State Phone Company will install the independent phone line from the existing phone board to the FACP. Once this is complete, Protection Services, Inc. will install a quick connect to the independent potts line for the FACP. Installation is to be completed by 12/17/13. 3.) Maintenance Director in-serviced all				
				department heads on the location of qui connect line and the procedure to test th FAPC system. 4.) The results of the monthly tests will	ck e			
				reported during the monthly Performance Improvement meeting for 3 months	e	12/20/13		

If continuation sheet Page 4 of 4

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED				
		345172	B. WING		11/27/2013				
NAME OF PROVIDER OR SUPPLIER TRIAD CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET HIGH POINT, NC 27262					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
K 051	Continued From page 3		ΚO	051					
K 089 SS≖O	A. The phone conibe tested as they could be tested as they could be tested as they could be tested as they could be tested as they could be tested as the could be tested as the could be tested as the could be tested as the could be tested as the could be tested as the could be tested as the could be tested as the could be tested as the could be tested as the could be tested as the could be tested as the could be tested as the could be tested as the could be tested as the could be tested as the could be tested as the could be tested as the could be tested as they could be tested as they could be tested as they could be tested as they could be tested as they could be tested as they could be tested as they could be tested as they could be tested as they could be tested as the could be tested as t		К 0	1.) Triad Pressure Wash, made a servito inspect the Ansul system for the rarin the kitchen. Ansul system was brown in compliance on 12/11/13. 2) The Maintenance Director will ensurance Ansul system is inspected every six mand is on the Preventive Maintenance Program/TELS System. 3) The Maintenance Director was educed with Wright, Regional Property Marrelated to the requirements of the Ansulant System inspection on 12/10/13. 4) The results of the inspections will be reported during the monthly Performal Improvement meeting for 3 months.	ge hood ght back are that onths cated by ager al	12/20/13			