PRINTED: 11/25/2014 FORM APPROVED OMB NO. 0938-0391

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                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | , ,                                                                                                                                                                                                                                                                                                                     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| ACCURACY/COOR  The assessment management is status.  A registered nurse each assessment was participation of head in a sessment is come.  Each individual who assessment must is that portion of the admits that p | ust accurately reflect the  must conduct or coordinate with the appropriate lth professionals.  must sign and certify that the upleted.  completes a portion of the sign and certify the accuracy of assessment.  d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than assessment; or an individual who gly causes another individual and false statement in a not is subject to a civil money at than \$5,000 for each  ent does not constitute a statement.  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A registered nurse each assessment v participation of hea  A registered nurse assessment is com Each individual who assessment must s that portion of the a  Under Medicare an willfully and knowin false statement in a subject to a civil mo \$1,000 for each ass willfully and knowin to certify a material resident assessme penalty of not more assessment.  Clinical disagreeme material and false s  This REQUIREMEN by: Based on staff inte facility failed to assi residents (Resident the Minimum Data  The findings include | BROOK REHABILITATION AND CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by:  Based on staff interview and record review the facility failed to assess one of three sampled residents (Resident #2) as having behaviors on the Minimum Data Set assessment. | ROVIDER OR SUPPLIER  BROOK REHABILITATION AND CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  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The findings included: | ROVIDER OR SUPPLIER  BROOK REHABILITATION AND CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (ADACH DEFICIENCY)  SUMMARY STATEMENT OF DEFICIENCIES (ACH DEFICIENCY)  ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment in a resident assessment.  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by:  Based on staff interview and record review the facility failed to assess one of three sampled residents (Resident #2) as having behaviors on the Minimum Data Set assessment.  The findings included: | A BUILDING COM COMPONENT OF THE PROVIDER OR SUPPLIER  BROOK REHABILITATION AND CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MAN THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MAN THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  THE assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment must sign and certify the accuracy of that portion of the assessment.  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This REQUIREMENT is not met as evidenced by:  Based on staff interview and record review the facility failed to assess one of three sampled residents (Resident #2), as having behaviors on the Minimum Data Set assessment.  The findings included:  F 278 Accuracy of Resident Assessment with the Assessment Reference Date 9/17/1/4 was modified on 10/10/14 by the Minimum Data Set Coordinator to reflect the |  |

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

TITLE

**Electronically Signed** 

10/20/2014

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

|                          | OF DEFICIENCIES<br>F CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ` '                |     | E CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | E SURVEY<br>PLETED         |
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| NAME OF F                | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 00/0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 30/2014                    |
| WILLOW                   | BROOK REHABILITA                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TION AND CARE CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                    |     | 33 EAST LEE STREET<br>ADKINVILLE, NC 27055                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | BE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X5)<br>COMPLETION<br>DATE |
| F 278                    | 11/9/2012 with diag disease, osteoarthr resided on a locked Review of the nurse 11 p) indicated Residents and trying to Geri chair." The recopperhead and I dineeded (PRN) Ativa PM and 10:00 PM.  The Minimum Data indicated Resident cognition and mem Resident #2 as have There were no behavior and the MDS.  Interview with the MPM revealed she has as having behaviors. The MDS nurse was behaviors in Septer timeframe for the lanurse's note dated the MDS. | dmitted to the facility on nosis including Alzheimer's itis and diabetes. Resident #2 d Alzheimer's unit.  e's notes dated 9/17/14 (3 p - ident #2 was "trying to get out work on another resident's sident stated "there is a lon't have my knife." The as an was administered at 6:00  Set (MDS) dated 9/17/14 #2 was severely impaired in ory. The MDS assessed ing behaviors of wandering. aviors of physical or verbal viors with others assessed on MDS nurse on 9/30/14 at 2:14 and not assessed Resident #2 is other than the wandering. Is not aware Resident #2 had mber during the assessment at MDS. She had not read the 9/17/14 prior to completion of | F 2                |     | documented behaviors.  Residents currently residing in the fithat exhibit behaviors have the pote be affected. For residents currently residing in the facility that exhibit behaviors, a review of the most recompleted Minimum Data Set Assessment was completed on or 10/29/2014 by the Minimum Data Scoordinator to ensure that behavior exhibited within the assessment refperiod were accurately coded on the MDS.  Re-education has been conducted the Licensed Nurse whose function Minimum Data Set Coordinator on before 10/29/2014 by the Regional Mix Coordinator. Quality Improvem monitoring will be conducted by the MDSC/Administrative Nurse to ensure that documented behaviors within the assessment reference period have coded accurately on the MDS. This Quality Improvement Monitoring will completed three times per week for weeks, then two times per week for weeks, then two times per week for weeks, then weekly for four weeks.  Results of the Quality Improvement Monitoring will be discussed at the monthly Quality Assurance Perform Improvement Committee Meeting for three months. The committee will recommend revisions to the plan to sustain substantial compliance. | ential to ential | 40,00444                   |
| F 280                    | 483.20(d)(3), 483.1                                                                                                                                                                                                                                                                                                                                                                                                                                                  | U(K)(Z) KIGHT TU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | F 2                | 280 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 10/30/14                   |

|                          | OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                | ` '                 | PLE CONSTRUCTION  G                                                                                                                                                                                                                                                                                                                                              | (X3) DATE SURVEY<br>COMPLETED                   |  |
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|                          |                                                                                                                                                                                                                                                                                                                                       | 345466                                                                                            | B. WING             |                                                                                                                                                                                                                                                                                                                                                                  | C<br><b>09/30/2014</b>                          |  |
|                          | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                  | ATION AND CARE CENTER                                                                             |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  333 EAST LEE STREET  YADKINVILLE, NC 27055                                                                                                                                                                                                                                                                                | , STATE, ZIP CODE<br>T                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                       | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)                                                                                                                                                                                                                                                     | D BE COMPLÉTION                                 |  |
| F 280<br>SS=D            | PARTICIPATE PLA  The resident has the incompetent or othe incapacitated under participate in plant changes in care and a comprehensive of within 7 days after comprehensive as interdisciplinary teaphysician, a register for the resident, and disciplines as deter and, to the extent of the resident, the resident representative. | ne right, unless adjudged erwise found to be the laws of the State, to ling care and treatment or | F 28                |                                                                                                                                                                                                                                                                                                                                                                  |                                                 |  |
|                          | by: Based on observarecord review the fiplan to include non behaviors prior to a medication and ide of three sampled remedications. Resi The findings include Resident #2 was a 11/9/2012 with diag                                                                                                                                   |                                                                                                   |                     | F 280 Revising and Updating the Resident Care Plan  For Resident #2, the care plan was updated on or before 10/29/2014 Minimum Data Set Coordinator to the residentNs behaviors.  Residents currently residing in the have the potential to be affected. MDSC has conducted a review of plans for current residents residing facility on or before 10/29/2014 to | by the reflect e facility The the care g in the |  |

| , ,                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                           | ` '                |     | E CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | СОМІ                                                                                     | E SURVEY<br>PLETED         |
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|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 345466                                                                                                       | B. WING            |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                          | 3 <b>0/2014</b>            |
|                          | PROVIDER OR SUPPLIE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | R FATION AND CARE CENTER                                                                                     |                    | 33  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>33 EAST LEE STREET<br>ADKINVILLE, NC 27055                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1 00/0                                                                                   | 50/2014                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                      | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ) BE                                                                                     | (X5)<br>COMPLETION<br>DATE |
| F 280                    | Physician orders Ativan 1 milligram the tongue (sublir needed for agitati Review of the Aug Administration Re (as needed) Ativ administered elev was administered for a total dose of administered four total dose of 4mg medication was a as agitation.  Review of the nur 10:00 PM reveale furniture, trying to fights with other re- scratching-scratch hands of staff who given with no effe 9:45 PM. Reside Resident constan re-educated, with Review of the nur PM revealed Res received PRN Ativ PM). Resident #2 "agitated/anxious documented. The indicated Resider "staggering" at 5 keep the resident | ed Alzheimer's unit.  dated 3/25/14 included use of (mg) to be administered under (ngual) every two hours as |                    | 280 | that residents exhibiting behaviors these behaviors documented on the plan.  Re-education has been provided to Interdisciplinary Team including the by the Regional Case Mix Coordin or before 10/29/2014 regarding up resident care plans to include reside behaviors. Quality improvement monitoring will be conducted by the MDSC for (5) resident care plans to times per week for four weeks, the weekly for four weeks to ensure the residents exhibiting behaviors have behaviors documented on the care.  Results of the Quality Improvement monitoring will be discussed by the Assurance Performance Improvement Committee at the Quality Assurance Performance Improvement Committee at the Quality Committee at the Quality Assurance Performance Improvement Committee in QAPI committee will discuss any necessary revisions to the plan to substantial compliance. | o the e MDSC ator on dating dent e hree en two en at e plan. et Quality nent ce ittee he |                            |

|                          | OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ` '                 | TIPLE CONSTRUCTION ING                                                     | CON                            | TE SURVEY<br>MPLETED       |
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|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 345466                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | B. WING             |                                                                            |                                | C<br>/ <b>30/2014</b>      |
|                          | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ATION AND CARE CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     | STREET ADDRESS, CITY, STATE, ZIF 333 EAST LEE STREET YADKINVILLE, NC 27055 |                                | 730/2014                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFI)<br>TAG |                                                                            | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 280                    | administration of the the nurse 's note) with Resident #2 wagitation was noted stick blood sugar callowed staff to che Documentation corgiven, resident squ staff members. " (the Ativan was doc The second entry fincluded 8:30 PM Fincluded 8:30 PM Fincluded 8:30 PM Fincluded Resident cognition and mem Resident #2 as have There were no behinappropriate behat the MDS.  The updated care problems of wanded of voiding in the floodeveloping drug refreceiving an antide medication and cur Resident enjoys more than the modern shift, resident him with toileting an attempting to void in behaviors, observe from medication are encourage resident. | RN ativan given. " (No time of the Ativan was documented in The documentation continued as squeezing staff hands and the refused to have a finger thecked, was redirected and the this blood sugar. Intinued with "PRN Ativan the region hands and fingers of the thin the nurse's note.) for 8/21/14 for the 3p - 11p shift the resident #2 was swinging at the resident #2 was swinging at the resident #2 was severely impaired in the nurse's note.) for 8/21/14 for the 3p - 11p shift the resident #2 was swinging at the resident #2 was severely impaired in the nurse of physical or verbal the resident with others assessed on the locked unit, at risk for lated side effects due to pressant and an anti anxiety the resides in a locked unit. The approaches for staff any wandering behaviors the resident for side effects and redirect the resident when the floor, document any the resident for side effects and notify the physician, at to attend activities, observe vities and monitor attendance. | F 2                 | 80                                                                         |                                |                            |

|                          | OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                     | ` '                 | TIPLE CONSTRUCTION NG                                                                                                                        |                 | E SURVEY<br>IPLETED        |
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|                          |                                                                                                                                                                                                                                                                                                                | 345466                                                                                                                                                                                                                                                                                                                                                                                                    | B. WING             |                                                                                                                                              |                 | C<br><b>30/2014</b>        |
|                          | PROVIDER OR SUPPLIER  BROOK REHABILITA                                                                                                                                                                                                                                                                         | TION AND CARE CENTER                                                                                                                                                                                                                                                                                                                                                                                      |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  333 EAST LEE STREET  YADKINVILLE, NC 27055                                                            | 1 00/           | 30/2014                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                               | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)                                 | _D BE           | (X5)<br>COMPLETION<br>DATE |
| F 280                    | 11 p) indicated Res doors and trying to Geri chair." The rescopperhead and I d PRN Ativan was ad 10:00 PM.  Interview with the MPM revealed she had behaviors for use of a care plan in place for a "history" of be revealed she had do The MDS nurse was behaviors in Septer timeframe for the last constant. | e's notes dated 9/17/14 (3 p-ident #2 was "trying to get out work on another resident's sident stated "there is a on't have my knife." The ministered at 6:00 PM and  **IDS nurse on 9/30/14 at 2:14 ad not care planned target f the Ativan. There had been e prior to the 9/17/14 update ehaviors. Further interview iscontinued that care plan. s not aware Resident #2 had mber during the assessment | F 2                 | 80                                                                                                                                           |                 | 10/30/14                   |
| SS=D                     | Each resident must provide the necessary or maintain the high mental, and psychological accordance with the and plan of care.  This REQUIREMENT by: Based on observative record review the fatthickened liquids as                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                           |                     | F 309(D)  Resident # 2 was provided with N Thickened Liquids on 9/30/2014 N Certified NurseNs Assistant. The was assessed by the Licensed No | by the resident |                            |

|                          | OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                             | (X2) MULTIP<br>A. BUILDING | LE CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X3) DATE :<br>COMPI                                                                                                                                               |                            |
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| NAME OF F                | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                |                            | STREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1 00/01                                                                                                                                                            | 0/2014                     |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                |                            | 333 EAST LEE STREET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                    |                            |
| WILLOW                   | BROOK REHABILITA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ATION AND CARE CENTER                                                                                                                                                                          |                            | YADKINVILLE, NC 27055                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                 | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | .D BE                                                                                                                                                              | (X5)<br>COMPLETION<br>DATE |
| F 309                    | Continued From pa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | age 6                                                                                                                                                                                          | F 309                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                    |                            |
|                          | The findings includ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ed:                                                                                                                                                                                            |                            | there was no adverse effect to the resident.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | •                                                                                                                                                                  |                            |
|                          | 11/9/2012 with diag disease.  Review of a Speed dated 3/3/2014 ind modified barium sv 2/18/14. The swal aspiration when sw discharge summar Resident #2 tolerat well. The caregive instructions on thic appropriate consis  The Minimum Data indicated Resident cognition and mem Resident #2 as recassistance of one state of the updated care problem of a "hist liquids" with appropriate consisting and the updated care problem of a "hist liquids" with appropriate consisting and docuproblem of "nutrition to a state of the updated care problem of a "hist liquids" with appropriate consisting and docuproblem of "nutrition updated care problem of a "hist liquids" with appropriate consistency of a "hist liquids" with appropriate consistency of a "nutrition updated care problem of a "nutrition updated care updated care problem of a "nutrition updated care | plan as of 9/17/14 included a cory of refusing thickened paches including "approached reassuring manner, if are, re-approach resident at a sument any refusals noted." A dional risk "included |                            | Residents residing in the facility we physician Ns orders for thickened have the potential to be affected, of residents in the facility with physorders for thickened liquids was completed by the Director of Clinic Services/Administrative Nurses of before 10/30/2014 to ensure accurate physician Ns orders for thickened Observations by designated departmentagers were conducted on roor rounds on or before 10/30/2014 to that residents with orders for thick liquids have thickened liquids avantheir room. A review of tray tickets conducted on or before 10/30/2014 ensure that residents with orders thickened liquids had the approprior order on the tray ticket. An observational provided at mealtimes has conducted on or before 10/30/2010 Dietary Manager/Administrative Nensure that liquids provided were consistent with what was docume the tray ticket. Thickened Liquids available in the nourishment kitch nursing staff to have available to provide the stage of the sta | liquids A review sicianNs cal nor iracy of liquids. rtment on ensure sened ilable in swas 4 to for iate vation of been 4 by the lurse to inted on are also ens for |                            |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | vide nectar thick liquids, set up<br>resident and assist as needed<br>ls.                                                                                                                      |                            | to residents as indicated.  Re-education has been provided Director of Clinical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | by the                                                                                                                                                             |                            |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | tember physician 's monthly<br>diet order for nectar thickened                                                                                                                                 |                            | Services/Administrative Nurses to nursing staff on or before 10/30/2 regarding providing residents with sufficient fluid intake to maintain p                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 014                                                                                                                                                                |                            |
|                          | Resident #2 was o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | bserved at 12:10 PM on                                                                                                                                                                         |                            | hydration and health. Education a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                    |                            |

|                          | OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIP<br>A. BUILDING |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X3) DATE SURVEY<br>COMPLETED                                                                                                           |
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|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 345466                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | B. WING                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | C<br><b>09/30/2014</b>                                                                                                                  |
|                          | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ATION AND CARE CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ;                          | STREET ADDRESS, CITY, STATE, ZIP CODE  333 EAST LEE STREET  YADKINVILLE, NC 27055                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | BE COMPLÉTION                                                                                                                           |
| F 309                    | thickened to nectar was observed to compare the coffee. She furthe "one cup "due to Aide #1 indicated the providing one cup meals.  Interview with DON would expect the reliquids. She would see if he was allow interview indicated the resident to receive was OK.  Interview with nurs revealed Resident refrigerator. He re The coffee was the She gave no explain coffee as a thin liquity his medications with tray. He ate indicated the resident #2 receives the stray. He ate indicated the coughing episodes of the control of the coughing episodes. | offee in a cup that had not been consistency. Resident #2 bugh after taking sips of coffee ned.  #1 on 9/30/14 at 12:12 PM #2 had received regular rexplained the staff gave him refusals of thickened coffee. his was the usual practice of of coffee, not thickened, at  I on 9/30/14 at 12:14 PM she esident to receive thickened check with Speech Therapy to red thin coffee. Further she would expect an order for sive regular (thin) coffee if it  #1 on 9/30/14 at 12:17 PM #2 had thick liquids in the ceived thick liquids on his tray. I only thin liquid he received. Ination as to why staff gave with a nutritional supplement.  #3014 at 12:25 PM revealed ed nectar thickened liquids on dependently and had no further | F 309                      | included provision of fluids to reside between meals including residents of physicianNs orders for thickened liquids and to come out threatimes per day between meals to ince thickened liquids and to be offered to residents by nursing staff to begin of before 10/30/2014. Observations with conducted by the Director of Clinical Services /Executive Director/Administrative Nurses 3 time per week for 4 weeks, then 2 times week for 4 weeks, then weekly for 4 months to ensure that residents are offered fluids/liquids between meals include residents with orders for this liquids. Other systemic changes incoolers to be placed at the bedside residents with physicianNs orders for thickened liquids containing the appropriate physicians ordered liquids consistency to ensure that residents requiring thickened liquids have liquids available to them. Residents residing Hickory Hall will be provided liquids physicianNs ordered consistency be meals. Designated department mar will conduct room rounds three times week for four weeks, then two times week for four weeks, then two times week for four weeks, then weekly for months to ensure that the liquid consistency provided is the appropring physicianNs ordered consistency.  Results of the reviews and observations. | with juids. ovision e lude to on or ill be al mes per lude to ockened lude of or or ild saids ag on per etween nagers es per or 4 iiate |
|                          | by the surveyor an                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | d drank the thickened tea time without prompting.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                            | will be discussed by the Director of Clinical Services/Administrative Nurse/Dietary Manager monthly at t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | he                                                                                                                                      |

|                          | OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ` '                 |    | E CONSTRUCTION                                                                                                                                                                                   | COM       | E SURVEY<br>PLETED         |
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|                          | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | TION AND CARE CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     | 33 | TREET ADDRESS, CITY, STATE, ZIP CODE<br>33 EAST LEE STREET<br>ADKINVILLE, NC 27055                                                                                                               |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG | <  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)                                                                                | BE        | (X5)<br>COMPLETION<br>DATE |
| F 329<br>SS=D            | Interview with the the 2:40 PM revealed Fron caseload for specimenterview revealed fron caseload for specimenterview revealed from the knews for the results ability to swallow asked for a recent shallow for a recent should be reduced combinations for its us adverse consequents and the shallow for a compression of the shallow for a compressi | nerapy manager on 9/30/14 at Resident #2 was not currently beech therapy. Further ne was not aware of any ident since the last therapy manager expected Resident ectar thick liquids. As far as e no changes in the resident 'liquids. The nursing staff had speech evaluation.  EGIMEN IS FREE FROM RUGS  g regimen must be free from an An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of inces which indicate the dose or discontinued; or any | F3                  |    | Quality Assurance Performance Improvement Committee Meeting from months. The Quality Assurance Performance Improvement Commit recommend revisions to the plan to sustain substantial compliance. | ttee will | 10/30/14                   |

|                          | OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPI<br>A. BUILDING | LE CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X3) DATE SURVEY<br>COMPLETED                              |
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| NAME OF F                | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                         |                             | STREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 00/00/2014                                                 |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                         | 3                           | 33 EAST LEE STREET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                            |
| WILLOW                   | BROOK REHABILITA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ATION AND CARE CENTER                                                                                                                                                                                                                                                                                                                                                                                   | )                           | ADKINVILLE, NC 27055                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | BE COMPLÉTION                                              |
| F 329                    | Continued From pa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | age 9                                                                                                                                                                                                                                                                                                                                                                                                   | F 329                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                            |
| 1 329                    | This REQUIREME by: Based on observarecord review the fund interventions administering an an attempt a dose red sampled residents medications. Resident #2 was a 11/9/2012 with diag disease, osteoarth resided on a locked Physician orders distributed for agitation Review of the Augu Administration Recident (as needed) Ativated administered elever was administered for a total dose of a administered four the same control of the | NT is not met as evidenced tions, staff interviews and acility failed to implement non for behaviors prior to nti-anxiety medication and uction for one of three receiving anti-anxiety dent #2.  ed:  dmitted to the facility on gnosis including Alzheimer's ritis and diabetes. Resident #2 d Alzheimer's unit.  ated 3/25/14 included use of (mg) to be administered under gual) every two hours as | F 329                       | F 329 Un-necessary Medications  For Resident #2, the pharmacy has conducted a medication regimen re on or before 10/29/2014. Resident seen by the NP on 10/1/14 for Med Review and adjustment of Psychotr Medications.  Residents residing in the facility has potential to be affected. A pharmac representative has conducted a medication regimen review for residurently residing in the facility on o before 10/29/2014.  Re-education has been provided to currently employed Licensed Nurse the Director of Clinical Services/Administrative Nurse regather regulation for un-necessary medications, documentation of effectiveness of medications, and utilization of non-pharmacological interventions prior to administration anxiolytic medications.  Quality Improvement monitoring will | eview #2 was ication ropic  ve the y dents r  es by arding |
|                          | medication was ad as agitation.  Review of the nurs 10:00 PM revealed furniture, trying to I fights with other research.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | e's notes dated 8/11/14 at Resident #2 was "moving eave facility, trying to start                                                                                                                                                                                                                                                                                                                       |                             | conducted via the Director of Clinics<br>Services/Administrative Nurse to er<br>that non-pharmacological interventi<br>have been attempted and that ratio<br>for use and effectiveness of the prin<br>medication are documented on the<br>Medication Administration Record.<br>monitoring will be conducted by the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | al<br>nsure<br>ons<br>nale<br>The QI                       |

|                          | OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ` '                |     | E CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                      | (X3) DATE S<br>COMPLE                    |                            |
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| NAME OF I                | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                | 03/0                                     | 00/2014                    |
| WILLOW                   | BROOK REHABILITA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TION AND CARE CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |     | 33 EAST LEE STREET<br>ADKINVILLE, NC 27055                                                                                                                                                                                                                                                                                                                                          |                                          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIOI<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY)                                                                                                                                                                                                                                                                   | BE                                       | (X5)<br>COMPLETION<br>DATE |
| F 329                    | hands of staff wher given with no effect 9:45 PM. Resident Resident constantly re-educated, with li Review of the nurse PM revealed Resid received PRN Ativa PM). Resident #2 "agitated/anxious documented. The indicated Resident "staggering" at 5:0 keep the resident shitting on PT (physiother residents. Pradministration of the nurse's note) with Resident #2 wagitation was noted stick blood sugar of allowed staff to che Documentation corgiven, resident squ staff members." (I Ativan was documented 8:30 PM Fistaff. There were reinterventions atternincident or the second entry for 8/2 included 8:30 PM Fistaff. There were no docinterventions atternincident or the second entry for 8/2 included 8:30 PM Fistaff. There were no docinterventions atternincident or the second entry for 8/2 included 8:30 PM Fistaff. There were no docinterventions atternincident or the second entry for 8/2 included 8:30 PM Fistaff. There were no docinterventions atternincident or the second entry for 8/2 included 8:30 PM Fistaff. There were no docinterventions atternincident or the second entry for 8/2 included 8:30 PM Fistaff. There were no docinterventions atternincident or the second entry for 8/2 included 8:30 PM Fistaff. There were no docinterventions atternincident or the second entry for 8/2 included 8:30 PM Fistaff. There were no docinterventions atternincident or the second entry for 8/2 included 8:30 PM Fistaff. There were no docinterventions atternincident or the second entry for 8/2 included 8:30 PM Fistaff. There were no docinterventions atternincident or the second entry for 8/2 included 8:30 PM Fistaff. There were no docinterventions atternincident or the second entry for 8/2 included 8:30 PM Fistaff. | re-directing him. Ativan PRN to until later in evening after a now resting in room.  y being re-directed & (and) title to no effect "  e's notes dated 8/21/14 at 1:45 ent #2 was confused and an 2 times that shift (7AM to 3 was described as " with no other behaviors nurse's note dated (3p -11p) #2 was up trying to walk and 0 PM. The staff was unable to eated. "After supper resident cal therapy) staff & pushing RN ativan given." (No time of e Ativan was documented in The documentation continued as squeezing staff hands and I. He refused to have a finger hecked, was redirected and eck his blood sugar. Intinued with "PRN Ativan eezing hands and fingers of No time of administration of the ented in the nurse's note.) The 21/14 for the 3p - 11p shift Resident #2 was swinging at no documented non drug pted on the 7AM to 3 PM shift. | F3                 | 329 | Director of Clinical Services/Administrative Nurse (3) to per week for (4) weeks, then (2) tin week for (4) weeks, then weekly fo weeks. Results of the Quality Improvement Monitoring will be discussed in the Assurance Performance Improvem Committee Meeting monthly for (3) months. The QAPI committee will recommend revisions to the plan to sustain substantial compliance. | nes per<br>r (4)<br>t<br>Quality<br>nent |                            |

| AND DUAN OF CODDECTION DENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                        | TIPLE CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     | (X3) DATE SURVEY<br>COMPLETED                                          |                                   |                            |
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|                                              |                                                                                                                                                                                                                                                                                        | 345466                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | B. WING             |                                                                        | ng                                | C<br>/ <b>30/2014</b>      |
|                                              | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                   | TION AND CARE CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     | STREET ADDRESS, CITY, STATE, 333 EAST LEE STREET YADKINVILLE, NC 27055 |                                   | 750/2014                   |
| (X4) ID<br>PREFIX<br>TAG                     | (EACH DEFICIENCY                                                                                                                                                                                                                                                                       | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG |                                                                        | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 329                                        | Continued From pa                                                                                                                                                                                                                                                                      | ge 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | F 3                 | 329                                                                    |                                   |                            |
|                                              | The nurse's notes f administration in Au                                                                                                                                                                                                                                               | or the days/times of Ativan igust did not include pted prior to administration of                                                                                                                                                                                                                                                                                                                                                                                                        |                     |                                                                        |                                   |                            |
|                                              | indicated Resident<br>cognition and mem<br>Resident #2 as hav<br>There were no beha                                                                                                                                                                                                    | Set (MDS) dated 9/17/14<br>#2 was severely impaired in<br>ory. The MDS assessed<br>ing behaviors of wandering.<br>aviors of physical or verbal<br>viors with others assessed on                                                                                                                                                                                                                                                                                                          |                     |                                                                        |                                   |                            |
|                                              | problems of wande of voiding in the flood developing drug rel receiving an antide medication and cur Resident enjoys muTV and helping othe included document each shift, resident him with toileting ar attempting to void in behaviors, observe from medication an encourage resident | plan as of 9/17/14 included ering/elopement risk, episodes or in the locked unit, at risk for ated side effects due to pressant and an anti anxiety rently resides in a locked unit. Usic, exercises, outings, food, ers. The approaches for staff any wandering behaviors resided in a locked unit, assist and redirect the resident when in the floor, document any the resident for side effects d notify the physician, to attend activities, observe wities and monitor attendance. |                     |                                                                        |                                   |                            |
|                                              | PRN Ativan had be medication was adr 9/16, 9/17 and 9/29 indicated the Ativan a second dose was documentation of formal properties.                                                                                                                                                    | ember 2014 MAR revealed<br>en given nine times. The<br>ministered on 9/3, 9/7, 9/10,<br>1/14. Review of the MAR<br>was not always effective and<br>then given. The MAR<br>ollow up for effectiveness of<br>not present for each time of                                                                                                                                                                                                                                                  |                     |                                                                        |                                   |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ` '                | (X2) MULTIPLE CONSTRUCTION A. BUILDING |                                                                                                                        |        | (X3) DATE SURVEY<br>COMPLETED |  |
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|                                                     | NAME OF PROVIDER OR SUPPLIER  WILLOWBROOK REHABILITATION AND CARE CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    | 33                                     | TREET ADDRESS, CITY, STATE, ZIP CODE  33 EAST LEE STREET  ADKINVILLE, NC 27055                                         | 1 00/1 | 50/2014                       |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFI<br>TAG |                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |        | (X5)<br>COMPLETION<br>DATE    |  |
| F 329                                               | p) revealed the resigned touching other kept asking for his resident was his will but he continued to The PRN Ativan wanoted.  There were no nursed.  There were no nursed.  Review of the nursed 3-11 shift revealed PM (no documente effectiveness noted 10:05 PM for behaviors of PRN Ativan at 5:00 "restlessness and a behaviors of "pacinhis wife, and "trying did not indicate nor attempted prior to a Review of the nursed 11 p) indicated Resident point in the properties and trying to Geri chair." The recopperhead and I copperhead and | e's note dated 9/3/14 (3 p - 11 ident was wandering in the unit residents inappropriately. He wife and thought another fe. Staff attempted to redirect, "think back on same issue." as given at 3:45 PM with effect se's notes for review for 9/7/14. The short of the PRN Ativan was given at 6:15 d behaviors) and with "no d." PRN Ativan was given at vior of "almost at a running inted non drug interventions did prior to administration of the PM and 7:10 PM for agitation." Resident #2 had ag in the unit" and looking for g the main doors." The note in drug interventions were administration of the Ativan.  The sident #2 was "trying to get out work on another resident's sident stated "there is a don't have my knife." The liministered at 6:00 PM and the did not indicate non drug attempted prior to | F3                 | 329                                    |                                                                                                                        |        |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ` '                |                                                                                   | E CONSTRUCTION                                                                                                  | COM  | E SURVEY<br>PLETED         |  |  |
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|                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 345466                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | B. WING            |                                                                                   |                                                                                                                 |      | C<br>30/2014               |  |  |
|                                                        | NAME OF PROVIDER OR SUPPLIER  WILLOWBROOK REHABILITATION AND CARE CENTER                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    | STREET ADDRESS, CITY, STATE, ZIP CODE  333 EAST LEE STREET  YADKINVILLE, NC 27055 |                                                                                                                 |      | 09/30/2014<br>≣            |  |  |
| (X4) ID<br>PREFIX<br>TAG                               | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFI<br>TAG | X                                                                                 | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE | (X5)<br>COMPLETION<br>DATE |  |  |
| F 329                                                  | Continued From pa There were no nurs 9/29/14.                                                                                                                                                                                                                                                                                                                                                                                                                   | ge 13<br>se's notes for review for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | F3                 | 29                                                                                |                                                                                                                 |      |                            |  |  |
|                                                        | until 12:00 PM reve<br>on the couch in a si<br>remained asleep ur<br>with frequent interv<br>PM. Activities were<br>time and he did not<br>completely.                                                                                                                                                                                                                                                                                                          | tions on 9/30/14 at 10:00 AM aled Resident #2 was asleep atting position. Resident #2 atil 10:33 AM and would nap als of being awake until 12:00 being provided during this participate or wake up                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |                                                                                   |                                                                                                                 |      |                            |  |  |
|                                                        | PM with nurse # 2 v on the evening shift Resident #2 was up getting in his space been given due to t with the other resid did not work in the #2 had not informed #2's recent behavior been attempted with with the resident, or hand. She further calmed down, he who be able to go to sle Continued interview Resident #2 did not explained she did not explained she did not ried unless it was behaviors Resident as "He will go to do them, look for (name | anducted on 9/30/14 at 3:30 who worked with Resident #2 to Nurse #2 explained best due to another resident on 9/10/14. The Ativan had he resident being "upset" ent. This nurse explained she unit on a regular basis. Nurse do the physician of Resident was. Interventions that had he Resident #2 included sitting ffering a snack, or holding his explained "If he does not get ill be so agitated he would not ep later on in the shift." A revealed redirection with a always work. Nurse #2 ot document what she had "a big deal." Frequent #2 exhibited were explained fors and attempt to open he) his wife and wander." |                    |                                                                                   |                                                                                                                 |      |                            |  |  |
|                                                        | chart review notes                                                                                                                                                                                                                                                                                                                                                                                                                                              | ulting pharmacist's monthly revealed no recommendations or recommendation to the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                    |                                                                                   |                                                                                                                 |      |                            |  |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION A. BUILDING                                                                                        |                                                                                                                                                                                             | (X3) DATE SURVEY<br>COMPLETED |                            |
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|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 245466                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                             |                               | 0                          |
|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 345466                                                                                                                                                                                                                                                                                                                                                       | B. WING _                                                                                                                     |                                                                                                                                                                                             | 09/                           | 30/2014                    |
| NAME OF PROVIDER OR SUPPLIER  WILLOWBROOK REHABILITATION AND CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE  333 EAST LEE STREET  YADKINVILLE, NC 27055                                                                                                           |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                              | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                                                                                                                                                                                             | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 329 F 428 SS=D                                                         | Interview with cons at 4:32 PM revealed Ativan use in her machine pharmacist further was receiving Ativamenth and nursing effective at times, so recommendation to pharmacist indicate recommendation or address and the second at least of pharmacist.  The drug regiment of reviewed at least of pharmacist.  The pharmacist must the attending physical at 1:32 PM revealed at 1:32 PM revealed at 1:32 PM reviewed at 1:32 PM revealed | verses benefit for the use of a requested.  ulting pharmacist on 9/30/14 d she did not address the conthly review notes. The explained since the resident in multiple times during the documenting it was not she should have made a or the physician. The ed she would have made a or the physician for a different essed the issue.  EGIMEN REVIEW, REPORT | F 32                                                                                                                          |                                                                                                                                                                                             |                               | 10/30/14                   |
|                                                                          | by: Based on observatinterview and record to review a resident and recommend a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | NT is not met as evidenced tions, consulting pharmacist d review the pharmacist failed t for unnecessary medication gradual dose reduction for one esidents receiving anti anxiety dent #2.                                                                                                                                                                  |                                                                                                                               | F 428  For Resident #2, the pharmacy has conducted a medication regimen re on or before 10/29/2014. Resident # seen by the NP on 10/1/14 for Medi Review and adjustment of Psychotromatics. | view<br>#2 was<br>cation      |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                    | . ,                 | LE CONSTRUCTION                                                                                                                      | (X3) DATE SURVEY<br>COMPLETED                                                             |  |
|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--|
|                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 345466                                                                                                                                                                                                | B. WING             |                                                                                                                                      | C<br><b>09/30/2014</b>                                                                    |  |
|                                                  | NAME OF PROVIDER OR SUPPLIER  WILLOWBROOK REHABILITATION AND CARE CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                       |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  333 EAST LEE STREET  YADKINVILLE, NC 27055                                                    |                                                                                           |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)                      | BE COMPLÉTION                                                                             |  |
| F 428                                            | The findings includ Resident #2 was ad 11/9/2012 with diag disease, osteoarthr resided on a locked Physician orders da Ativan 1 milligram ( the tongue (subling needed for agitation Review of the Augu Administration Rec (as needed) Ativa administered eleve was administered t for a total dose of 3 administered four t total dose of 4 mg of medication was ad as agitation.  Review of the Sept PRN Ativan had be medication was ad 9/16, 9/17 and 9/29 indicated the Ativar a second dose was documentation of fothe medication was administration.  Review of the cons | ed: dmitted to the facility on gnosis including Alzheimer 's ritis and diabetes. Resident #2 d Alzheimer 's unit. ated 3/25/14 included use of (mg) to be administered under gual) every two hours as | F 428               | ,                                                                                                                                    | dents or or es by arding n of prn nducted nsure ions onale n The QI estimes nes per r (4) |  |
|                                                  | for a dose reduction                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | n or recommendation to the verses benefit for the use of                                                                                                                                              |                     | Monitoring will be discussed in the Assurance Performance Improvem Committee Meeting monthly for (3) months. The QAPI committee will | Quality<br>nent                                                                           |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                               | , ,     |                                                                                                                  | E CONSTRUCTION                                                     | (X3) DATE SURVEY<br>COMPLETED |                            |
|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------|----------------------------|
|                                                     |                                                                                                                                                                                                                                                                                                                                            | 345466                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | B. WING |                                                                                                                  |                                                                    |                               | 30/ <b>2014</b>            |
| NAME OF F                                           | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |         | S                                                                                                                | TREET ADDRESS, CITY, STATE, ZIP CODE                               | 1 00/                         | 30/2014                    |
|                                                     |                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |         | 33                                                                                                               | 33 EAST LEE STREET                                                 |                               |                            |
| WILLOW                                              | BROOK REHABILITA                                                                                                                                                                                                                                                                                                                           | ATION AND CARE CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |         | Y                                                                                                                | ADKINVILLE, NC 27055                                               |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |         | ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY) |                                                                    | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 428                                               | Continued observa until 12:00 PM reve on the couch in a s remained asleep u with frequent interved. Activities were time and he did not completely.  Interview with constat 4:32 PM reveale Ativan use in her machine pharmacist further was receiving Ativa month and nursing effective at times, s recommendation to pharmacist indicate | attions on 9/30/14 at 10:00 AM ealed Resident #2 was asleep sitting position. Resident #2 ntil 10:33 AM and would nap vals of being awake until 12:00 to being provided during this transfer participate or wake up sulting pharmacist on 9/30/14 and she did not address the monthly review notes. The explained since the resident an multiple times during the documenting it was not she should have made a to the physician. The ead she would have made a to the physician for a different | F 4     | 128                                                                                                              | recommend revisions to the plan to sustain substantial compliance. |                               |                            |