MENT OF HEALTH	AND HUMAN SERVICES			M APPROVED
RS FOR MEDICARE	& MEDICAID SERVICES		-	O. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ATE SURVEY OMPLETED
345051			1	C 2/17/2014
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			405 SOUTH GREENE STREET	
NEALIN AND RENAD	IEITATION		WADESBORO, NC 28170	
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
INITIAL COMMENT	ſS	F 00	0	
		F 30	9	1/5/15
provide the necess or maintain the high mental, and psycho	ary care and services to attain nest practicable physical, psocial well-being, in			
by: Based on record re facility failed to obta laboratory results a 1 of 5 (resident #49 unnecessary medic lidoderm patch as c of 5 (resident #84) unnecessary medic 1. Resident #49 wa 11/18/10 with multip III Renal Disease, D Dementia, Hyperter Pulmonary Disease Cardiomyopathy, an Disorder. A review of the Min revealed the reside of a diuretic medica	eviews and staff interviews, the ain stat (immediately) s ordered by the physician for b) residents reviewed for sations and failed to administer ordered by the physician for 1 residents reviewed for sations. s admitted to the facility on ble diagnoses including Stage Diabetes Mellitus II, Ascities, nsion, Chronic Obstructive e, Congestive Heart Failure, nd Behavior Depressive	NATI IPE	<ul> <li>of Correction does not constitute admission or agreement by the provider the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely becaus it is required by the provisions of Federa and State law.</li> <li>F309 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being , in accordance with the comprehensive assessment pla of care.</li> <li>Corrective Action</li> </ul>	of e le
	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER HEALTH AND REHAB SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA INITIAL COMMENT No deficiencies we complaint investiga ID # 083911. 483.25 PROVIDE O HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho accordance with the and plan of care. This REQUIREMEN by: Based on record re facility failed to obta laboratory results a 1 of 5 (resident #49 unnecessary medic lidoderm patch as of of 5 (resident #49) unnecessary medic lidoderm patch as of of 5 (resident #49) unnecessary medic lidoderm patch as of of 5 (resident #49) unnecessary medic lidoderm patch as of of 5 (resident #49) wa 11/18/10 with multip III Renal Disease, D Dementia, Hyperter Pulmonary Disease Cardiomyopathy, an Disorder. A review of the Mini- revealed the reside of a diuretic medica	IDENTIFICATION NUMBER:         345051         PROVIDER OR SUPPLIER         HEALTH AND REHABILITATION         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         INITIAL COMMENTS         No deficiencies were cited as a result of the complaint investigation survey of 12/17/14. Event ID # 083911.         483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING         Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.         This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to obtain stat (immediately) laboratory results as ordered by the physician for 1 of 5 (resident #49) residents reviewed for unnecessary medications.         1. Resident #49 was admitted to the facility on 11/18/10 with multiple diagnoses including Stage III Renal Disease, Diabetes Mellitus II, Ascities, Dementia, Hypertension, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Cardiomyopathy, and Behavior Depressive Disorder.         A review of the Minimum Data Set dated 11/20/14 revealed the resident was assessed with the use of a diuretic medication.	RS FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES         OF DEFICIENCIES         PCORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         AB5051         B. WING	IMENT OF HEALTH AND HUMAN SERVICES       FOR         SP COM EDICARE & MEDICAID SERVICES       OMB N         or DEFICIENCIES       (X1) PROVIDERSUPPLERICLA       (X2) MULTIPLE CONSTRUCTION       (X3) D         A BULDING       345051       INVING       (X2)         PROVIDER OR SUPPLIER       405 SOUTH GREENE STREET       WADESBORO, NC 28170         HEALTH AND REHABILITATION       SUMMARY STATEMENT OF DEFICIENCIES       INVING       (X2) MULTIPLE CONSTRUCTION ON UMBER:         REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDER SPECTIVA OF ORBECTION       PROVIDER PLAN OF CORRECTIVE ACTION BOLD BE         REGULATORY OR LSC IDENTIFYING INFORMATION)       PREIN       TAG       PROVIDE CORRECTIVE ACTION HOURD BE         NO deficiencies were cited as a result of the complaint investigation survey of 12/17/14. Event ID # 063911.       F 000       F 309         INITIAL COMMENTS       F 000       F 309       F       Preparation and /or execution of this Pla of Correction is accordance with the comprehensive assessment and plan of care.       F 309         This REQUIREMENT is not met as evidenced by:       Based on record reviews and failed to administer iddorem pachas ordered by the physician for 1 of 5 (resident #49) residents reviewed for unnecessary medications and failed to administer indexessing enclusions and failed to administer prevealed hy the provide the necessary care and failed to administer prevealed by the provide the necessary care and failed to administer iddicencies. The Plan of Corr

Electronically Signed

(X6) DATE 01/01/2015

PRINTED: 03/19/2015

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	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI	E CONSTRUCTION	MB NO.	<u>0936-038</u> E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
	345051			•		С	
			B. WING			12/*	17/2014
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ANSON HEALTH AND REHABILITATION				4	05 SOUTH GREENE STREET		
ANSON	TEALIN AND RENAC	BIEITATION		V	VADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 309	Continued From pa	age 1	F 3	09			
		5			Resident #49 had another CBC an	d BMP	
	The Plan of Care d	ated 11/26/14 indicated the			drawn on 12/18/2014 with results r		
		otential for dehydration			to the Physician.		
		f diuretic medication. The			Resident #84Ks Lidocaine patch w	/as	
		led to monitor labs as ordered,			discontinued on 12/18/2014 per		
		at indicated dehydration and to of any abnormal lab values.			PhysicianKs order.		
		i of any aphormal lab values.			Corrective Action for those with the	<b>`</b>	
	A review of the Phy	vsician ' s Orders revealed an			potential to be effected	5	
		14 which stated "Complete					
		prehensive Metabolic Panel			An audit was done at the time of su	urvey	
	and Hemoglobin A	1C (Glycated Hemoglobin)			by the Director of Nurses (DON) a	nd /or	
	Stat. "				her nurse managers of all charts lo		
					for any potential missing labs. No o		
		ory results collected 11/27/14			resident was found to be affected b	by this	
		ved and reviewed by the facility			alleged deficient practice.	ofoll	
		onducted. The review revealed ium level equal to 5.9			Also at the time of survey an audit MARs was completed by the DON		
		(mmol/L) with a normal range			her nurse mangers for transcription		
		L to 5.1 mmol/L. The review			errors. No other resident was found		
		noglobin count equal to 8.7			affected by the alleged deficient pr		
		(g/dl) with a normal range			, , , , , , , , , , , , , , , , , , , ,		
		o 15.0 g/dl. The review also			Systemic Changes		
		natocrit level equal to 27% with					
	a normal range equ	ual to 34% to 44%.			A Lab log has been instituted for be		
	A review of the Phy	vsician ' s Orders revealed an			routine and Stat Labs. This Lab log reviewed in the morning Clinical M		
	5	14 which stated "Repeat			by the DON and Nurse Managers		
		ount and Basic Metabolic			compliance.		
	Panel in the mornin				All licensed staff have been reedu	cated	
		-			by the DON in the use of the Lab lo		
		onducted with Administrative			system between 12/29/2014 and		
		4 at 10:11 AM. She stated the			01/02/2015.		
		wn on 11/27/14 and sent to the			The Medical records clerk has bee		
		mediate evaluation and the			reeducated by the DON on 12/18/1		
		becimen to another laboratory			regarding proper thinning of charts		
		stated Administrative Staff #4 laboratory on more than one			missing Lidocaine patch was a res improper thinning of orders.		
		ested the lab results to be sent			All Licensed staff has been reeduc	atad	

Facility ID: 952941

If continuation sheet Page 2 of 10

		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345051		B. WING			C 12/17/2014	
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ANSON	HEALTH AND REHAB	BILITATION			05 SOUTH GREENE STREET /ADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From pa	age 2	F 3	09			
	unable to obtain the not indicate there w facility staff to follow she expected the re be received by the after being sent for 2. Resident #84 wa 3/25/13. Diagnose and chronic compla A Quarterly Minimu 11/24/14 indicated intact. The assess scheduled pain me receive any prn (as during the assessm Physician ' s orders an order dated 10/2 (patch used to relie is applied) on 12 A review of the Nov and the November Record (MAR) reve Lidoderm patch wa November physicia transcribed to the N	as admitted to the facility s included: arthritis of knees aints of pain. Im Data Set (MDS) dated Resident #84 was cognitively ment noted that she was on dication regime and did not needed) pain medication			regarding the proper transcription of Medications between 12/18/2014 to 12/31/2014 by the DON and Clinical Managers. All new licensed staff will be in service during their orientation period regard these two procedures. Monitoring The DON and/or her Nurse Manager review the Lab log on a daily basis in morning Clinical meeting in an ongoi basis. Results brought by the DON, will be reviewed in the monthly Quality Assu Performance Improvement (QAPI) meeting for 2 months for any further recommendations. Any recommenda will be the responsibility of the DON to carry out as per the committee. The DON and/or her Nurse Manager review 100% of the charts for transcr errors for 2 months and then 50% of MARS for 2 months and then random thereafter. Results will be reported by DON to the QAPI committee for 3 mo for further recommendations by the committee. The DON will be response to carry out any further recommendations to carry out any further recommendations by the	ced ling rs will n the ing urance ations to rs will ription the mly y the onths sible	
	was not having any chronic pain in her to arthritis. She sta	4PM, Resident #84 stated she pain at this time but she had legs and generalized pain due ated the pain was mostly in her she could not walk due to the					

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C			A. BUILDIN	G	C	
345051 B. WING				17/2014		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 405 SOUTH GREENE STREET		
ANSON I	ANSON HEALTH AND REHABILITATION			WADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309		-	F 30	9		
	month physician ord nurses check both i MARS on two differ #1 noted that the or checked on 10/28/1 the second check. signed by the family 11/12/14. She said follow physician ord transcribed the orde the November phys MAR. The Lidoder administered as ord	ders and MARS. She said two the physician orders and ent days. Administrative staff ders for November were 4 and no signature noted for The physician orders were 7 nurse practitioner on she expected nursing staff to ers and they should have er for the Lidoderm patch to ician order and the November m patch should have been lered.				
F 371 SS=E	practitioner (FNP) s resident # 84 did no for the month of No nursing staff would Lidoderm patch as 10/24/14. 483.35(i) FOOD PF	3AM, the family nurse tated she was unaware that of receive her Lidoderm patch vember and expected that have administered the ordered by the physician on COCURE, SERVE - SANITARY	F 37	1		1/5/15
	considered satisfac authorities; and	m sources approved or tory by Federal, State or local distribute and serve food litions				

Facility ID: 952941

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PRINTED: 03/19/2015

	-	AND HUMAN SERVICES			PRINTED: FORM OMB NO.	APPROVEI
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	345051		B. WING _		( 12/1	;  7/2014
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
ANSON HEALTH AND REHABILITATION			405 SOUTH GREENE STREET WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 371	Continued From pa	ge 4	F 37	71		
		NT is not met as evidenced				
	interview, the facilit dishwashing machi the wash temperatu	eview, observation and staff y failed to operate the ne properly in order to reach ure at 150 degrees Fahrenheit se temperature at 180 is included:		F371 The facility procures food fro approved or considered satis the State and Local authoriti prepares, and distributes the sanitary conditions.	sfactory by es and stores,	
	machine was obser	1:15 AM, the dishwashing ved with the administrative ietary Aide #1 was observed to		Corrective Action The Service company inspe	cted and	
	turn on the dishwas that the temperatur few minutes. The r 11:15 AM through 1 temperature was 12	shing machine. She stated es would start to go up after a nachine was observed from 1:45 AM, and the wash 22 degrees F and the final		serviced the dishmachine 1 and found both rinse tanks v properly and all temps looke Staff responsible for operatin dishwasher have been reed	2/19/2014 vere heating d good. ng the ucated in the	
	AM, Dietary Aide # <sup>2</sup> and stated that the more than 150 deg	vas 148 degrees F. At 11:46 I started to turn another knob temperatures would go up to rees for the wash and 180 se. The machine was again		proper operation of the equip temperature log is being use washing and monitored and the Dietary Manager or her a daily.	ed at each d reviewed by	
	observed from 11:5 the wash temperatu final rinse temperat Aide #1 further stat	0 AM through 12:00 noon and ure was 132 degrees F and the ure was 158 degrees. Dietary ed that she was just assigned		All Mighty Shakes were remains and dis Dietary Manager 12/17/2014	carded by the	
	on how to operate i Aide #2 was the pe	machine and was still learning t. She indicated that Dietary rson who was familiar with the puld come at 4:00 PM.		Corrective Action for those w potential to be effected All residents have the potent	tial to be	
	was interviewed. S working at the facili indicated that she v problem with the dis	5 PM, administrative staff #2 the stated that she just started ty about a week ago. She vas told that there was a shwashing machine and the ered. It was the first		affected by this alleged defic All nursing refrigerator in the inspected for any undated su including Mighty shakes by t Manager 12/27/2014. No oth dietary product was found.	facility were upplements, he Dietary	
		wash), the tray would not move		Systemic Changes		

Facility ID: 952941

If continuation sheet Page 5 of 10

STATEMENT	OF DEFICIENCIES CORRECTION	KOMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	СОМ	E SURVEY PLETED	
		345051	B. WING _			C 12/17/2014	
ANSON H	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 405 SOUTH GREENE STREET WADESBORO, NC 28170	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	forward. Administr that there was a pro- machine temperatu F for the wash and rinse but she was r On 12/17/14 at 5:19 was again observe observed to turn or final rinse temperat On 12/17/14 at 5:49 was interviewed. H the dishwashing map problem with the te thought the probler how to properly ope that he will educate the machine in the The dish machine for reviewed. Adminis find the temperatur September and Oc 2014 log revealed for order from Novemb and paper products 2014 log revealed for December 1 throug	anually push the tray to move ative staff #2 acknowledged oblem with the dishwashing ures not reaching 150 degrees 180 degrees F for the final not aware of the problem. 5 PM, dishwashing machine d. Dietary Aide #2 was in the machine. At 5:30 PM, the ture was 150 degrees F. 5 PM, administrative staff #3 de stated that he had checked achine and there was no emperatures. He added that he in was the staff did not know erate the machine. He stated a the staff on how to operate morning. temperature logs were trative staff #2 was not able to re log for the month of etober, 2014. The November, that the machine was out of ber 24 through December 1st is were used. The December, no temperatures recorded from gh 11.	F 37	<ul> <li>Dietary staff, including the Di Manager, have been reeduca Maintenance Director on 12/ proper operation of the dishwi including monitoring and doc of temperatures. The Dietary has been reeducated in the p of dietary products by the Adu 12-18-14.</li> <li>Monitoring</li> <li>The Dietary Manager will utili Audit tool to monitor proper ri dishwasher, proper use of the dishwasher, and proper datin products. This tool will be use basis for 2 weeks, then week weeks, then monthly x 2 mor results will be reported by the Manger to the monthly QAPI 3months for any further recommendations. The Dieta and the Administrator will the for carrying out any further recommendations by the con</li> </ul>	ted by the 18/14 to the vasher, umentation Manager proper dating ministrator on ze a Dietary inse temps of e g of the food ed on a daily ly for 2 tiths. The e Dietary committee x ary Manager responsible		
	On 12/17/14 at 2:4	5 PM, the nourishment					

If continuation sheet Page 6 of 10

STATEMENT OF OFFICIENCIES AND PLAN OF CORRECTION       (x1) PROVIDERSUPPLIER IDENTIFICATION NUMBER:       (x2) MULTIPLE CONSTRUCTION A BUILDING       (x3) DATE SURVEY COMPLETED B. WING         NAME OF PROVIDER OR SUPPLIER       345051       B. WING       (x1) TAG       STREET ADDRESS, CITY, STATE, ZIP CODE       C 12/17/2014         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       405 SOUTH GREENE STREET WADESBORO, NC 28170       (x9) (cACH DEPICIENCY WAS TREET PROCEDE BY FULL (CACH DEPICIENCY WAS TREET PROCEDE BY FULL (CACH DEPICIENCY WAS TREET PROCEDED BY FULL (CACH DEPICIENCY WAS TREET PROCEDED BY FULL (CACH DEPICIENCY WAS TREET PROCEDE BY FULL (CACH DEPICIENCY WAS TREET PROCEDED BY FULL (CACH DEPICIENCY WAS TREET ADDRESS, CITY, STATE, ZIP CODE       (x9) (x9) (CACH DEPICIENCY MUST BE PROCEDED BY FULL (CACH DEPICIENCY MUST BE PROCEDED BY FULL (CACH DEPICIENCY MUST BE PROCEDED BY FULL (CACH DEPICENCY MUST BE PROCEDED BY FULL (CACH DEPICENCY)       PROVIDERS PLAN OF CORRECTION (CACH DEPICENCY)       (x9) (x9) (CACH DEPICENCY)         F 371       Continued From page 6 refrigerator #1 (magnolia and rose halls) was observed. There were four cartons of great shakes observed with no date on them. The shakes were observed to have been thawed.       F 371       F 371         On 12/17/14 at 4:20 PM, administrative staff #2 was interviewed. She stated that she was just told that she was responsible for checking the nourishment refrigerator. She added that the facility 's policy was to discard the great shakes 14 days after they were placed in the refrigerator. 14 days after they were placed in the refrigerator. 14 days after they were placed in the refrigerator. 14 days after they were placed in the refrige			AND HUMAN SERVICES			FORM	: 03/19/2015 APPROVED : 0938-0391
12/17/2014       NAME OF PROVIDER OR SUPPLIER       ANSON HEALTH AND REHABILITATION       STREET ADDRESS, CITY, STATE, ZIP CODE       405 SOUTH GREENE STREET       MADE OF PROVIDER OR SUPPLIER     SUMMARY STATEMENT OF DEFICIENCIES       Image: Colspan="2">Image: Colspan="2">Image: Colspan="2">Colspan="2"Colspan="2"Colspan="2"Colspan="2"Colspan="2"Colspan="2"Cols	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         ANSON HEALTH AND REHABILITATION       STREET ADDRESS, CITY, STATE, ZIP CODE         (xi) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION MOUTH BAPPROPRIATE DEFICIENCY)       COMPLETION DATE         F 371       Continued From page 6 refrigerator #1 (magnolia and rose halls) was observed. There were four cartons of great shakes observed with no date on them. The shakes were observed to have been thawed.       F 371         On 12/17/14 at 2:50 PM, nourishment refrigerator #2 (dogwood and sunflower halls) was observed. There were five cartons of great shakes observed with no sticker/date.       F 371         On 12/17/14 at 4:20 PM, administrative staff #2 was interviewed. She stated that she was just told that she was responsible for checking the nourishment refrigerator. She also stated that it was her fault for not putting the sticker/date on the great shakes when she put them in the nourishment refrigerator. She added that the facility's policy was to discard the great shakes 14 days after they were placed in the refrigerator. F 431       F 431			345051	B. WING _			
ANSON HEALTH AND REHABILITATION       WADESBORO, NC 28170         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH DERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH DERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH DERICIENCY)       COMPLETION (EACH DERICIENCY)         F 371       Continued From page 6 refrigerator #1 (magnolia and rose halls) was observed. There were four cartons of great shakes observed with no date on them. The shakes were observed to have been thawed.       F 371       F 371         On 12/17/14 at 2:50 PM, nourishment refrigerator #2 (dogwood and sunflower halls) was observed, with no sticker/date.       F 371       On 12/17/14 at 2:50 PM, administrative staff #2 was interviewed. She stated that she was just told that she was responsible for checking the nourishment refrigerator for expired snacks/supplement products. She also stated that it was her fault for not putting the sticker/date on the great shakes when she put them in the nourishment refrigerator. She added that the facility 's policy was to discard the great shakes 14 days after they were placed in the refrigerator.       F 431       1/5/15	NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)       Community and the precedular and the p	ANSON H	HEALTH AND REHAB	ILITATION				
refrigerator #1 (magnolia and rose halls) was observed. There were four cartons of great shakes observed with no date on them. The shakes were observed to have been thawed. On 12/17/14 at 2:50 PM, nourishment refrigerator #2 (dogwood and sunflower halls) was observed. There were five cartons of great shakes observed with no sticker/date. On 12/17/14 at 4:20 PM, administrative staff #2 was interviewed. She stated that she was just told that she was responsible for checking the nourishment refrigerator for expired snacks/supplement products. She also stated that it was her fault for not putting the sticker/date on the great shakes when she put them in the nourishment refrigerator. She added that the facility's policy was to discard the great shakes 14 days after they were placed in the refrigerator. F 431 483.60(b), (d), (e) DRUG RECORDS, F 431 1/5/15	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	) BE	COMPLETION
SS=D       LABEL/STORE DRUGS & BIOLOGICALS         The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.         Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431	refrigerator #1 (mag observed. There w shakes observed w shakes were observed On 12/17/14 at 2:50 #2 (dogwood and s There were five car with no sticker/date On 12/17/14 at 4:20 was interviewed. S told that she was re nourishment refrige snacks/supplement that it was her fault on the great shakes nourishment refrige facility 's policy was 14 days after they w 483.60(b), (d), (e) D LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliant reconciled. Drugs and biological labeled in accordant professional princip	<ul> <li>gnolia and rose halls) was vere four cartons of great with no date on them. The ved to have been thawed.</li> <li>D PM, nourishment refrigerator unflower halls) was observed. tons of great shakes observed to so f great shakes observed to have been thawes observed.</li> <li>D PM, administrative staff #2</li> <li>D PM, ad</li></ul>		71		1/5/15

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE	E SURVEY PLETED
	345051		B. WING	-		C 12/17/2014	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	17/2014
ANSON HEALTH AND REHABILITATION					05 SOUTH GREENE STREET		
/				N	ADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	instructions, and the applicable. In accordance with facility must store a locked compartmer controls, and permi have access to the The facility must pro- permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except wher package drug distri	e expiration date when State and Federal laws, the Il drugs and biologicals in its under proper temperature t only authorized personnel to keys. Divide separately locked, I compartments for storage of ed in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can	F 45	31			
	by: 0431 Based on observati interviews, the facili multi-dose vials of i multi-dose vial of N one of two medicati date one Ventolin in findings included: 1. Manufacturer ' s influenza vaccine 2 part, " 16.2 storage stopper of the multi	NT is not met as evidenced on, record review and staff ity failed to date three opened influenza vaccine and one ovolin 70/30 insulin located in on refrigerators and failed to shaler when opened. The instructions for Afluria 014-2015 formula stated, in and handling. Once the dose vial has been pierced, carded within 28 days ".			F431 The drugs and biologicals used in the facility are labeled in accordance with currently accepted professional prime Corrective action The undated multidated vials of Flue vaccine, one insulin vial, and Vental inhaler were removed and discarded the DON at the time of survey. Corrective Action for those with the potential to be effected	ith nciples. lin	

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PRINTED: 03/19/2015

TATEMEN	OF DEFICIENCIES OF CORRECTION	KANNER STATE STREET STREE	```	IPLE CONSTRUCTION	СОМ	E SURVEY PLETED	
	345051		B. WING _			12/17/2014	
	PROVIDER OR SUPPLIER	BILITATION		STREET ADDRESS, CITY, STAT 405 SOUTH GREENE STREE WADESBORO, NC 28170	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE	
F 431	On 12/17/14 at 11:4 medication refriger room revealed thre vials of Afluria influe On 12/17/14 at 11:4 both stated the poli multi-dose vials wh vaccine should hav opened. On 12/17/14 at 11:5 stated nursing staff should have dated was opened. 2. Manufacturer ' si insulin reads, in pa vial after six (6) we there is insulin left i On 12.17.14 at 11:4 medication refriger room revealed one Novolin 70/30 insul On 12/17/14 at 11:4 both stated the poli multi-dose vials wh should have been of On 12/17/14 at 11:5	48AM, an observation of the ator in the main medication ee (3) opened and undated enza vaccine. 48AM, Nurse #1 and Nurse #2 icy of the facility was to date all en opened and the influenza ve been dated when it was first 55AM, Administrative staff #1 f should follow the policy and the influenza vaccine when it s instructions for Novolin 70/30 rt, "Throw away an opened eks (42 days) of use, even if in the vial ". 48AM, an observation of the ator in the main medication opened and undated vial of	F 43	At the time of notifical medicine, an audit of med carts was perfor her Assistant Director two RN unit manager Any undated items for at that time. Systemic Changes All Licensed staff har regarding proper dati between 12/17/2014 the DON. All new licensed staff regarding labeling an during their orientation Monitoring Medications, includin rooms, will be inspect or her RN Supervisor weekly x 2 weeks and months. Results of m reported by the DON meeting. Any further the committee will be the DON to carry out.	all med rooms and med by the DON, r of Nursing, and her s on 12/17/2014. and were corrected we been reeducated ng of medications and 12/31/2014 by will be educated d dating medications in period. g med carts and med ted daily by the DON r, x 2 weeks and d then monthly x3 ponitoring will be to the monthly QAPI recommendations by the responsibility of		

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		AND HUMAN SERVICES			FORM	03/19/2015 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COM	E SURVEY IPLETED
		345051	B. WING			C 17/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ANSON HEALTH AND REHABILITATION				105 SOUTH GREENE STREET NADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 431	3. The manufacture Ventolin HFA Inhala 2012 was reviewed HFA inhaler away a shows 000, after the Ventolin HFA packa open the foil pouch On 12/17/14 at 11:4 Dogwood medicatic and undated ventol An interview was co 12/17/14 at 12:00 F were expected to m with the date opene An interview was co Staff #1 on 12/17/14 nursing staff was no inhalers with the da nursing staff was exp	er's Patient Information for ation Aerosol dated October I. It stated "Throw the Ventolin is soon as the dose counter e expiration date on the aging, or 12 months after you , whichever comes first. " 45 AM an observation of the on cart revealed one opened in inhaler. onducted with Nurse #1 on PM. She stated the nurses nark all multi-dose medications	F 431			

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