	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		345051	B. WING			11/19/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				405 SOUTH GREENE STREET		
ANSON H	EALTH AND REHABIL	ITATION		WADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 222 SS=D	483.13(a) RIGHT T CHEMICAL RESTF	O BE FREE FROM RAINTS	F 2	22		12/9/15
	chemical restraints discipline or conver	e right to be free from any imposed for purposes of nience, and not required to medical symptoms.				
	by: Based on record re and physician inter a resident free of cl combative and agit 1 of 5 sampled resi findings included: Resident #14 was a diagnoses including dementia without b infarction. The Admission Min 10/30/15 revealed to impaired, rejected of antipsychotic medic The Hospital Disch revealed " On arriv agitated and canno after receiving 1 mg (antianxiety medica requiring 6 security hurting himself or th medication) 5 mg IN Summary also indio Resident #14 was " which was then m medication that car disorders) was add	NT is not met as evidenced eview, staff Nurse Practitioner view, the facility failed to keep hemical restraints for ated behaviors medication for dents (Resident #14). The admitted on 10/23/15 with g urinary tract infection, ehaviors and cerebral imum Data Set (MDS) dated the resident was cognitively care and had been on cations. arge Summary dated 10/23/15 val the patient is confused and t provide any history. Even g (milligram) of Ativan tion) IV (intravenously) he is guards to prevent him from he staff. Haldol (antipsychotic V given. " The Discharge cated due to combativeness " placed on sedation precedex educed and Depakote (a h be used to treat mood ed for agitation. The e diagnoses included "		F-222 Disclaimer Clause: Preparation and or execution does not constitute admissin agreement by the Provider of the facts alleged or conclusis the statement of deficiencies prepared and or executed s it is required by the provision and Federal law. Corrective action accompliss resident that was affected The medical record for Resi was reviewed by the adminin nursing team on 11/19/2015 appropriate medication order other concerns were identifit for Haldol 5mg po now and was a one-time order and e 11/17/15. Nurse #5 was ree behavior assessment/monitoring/inte antipsychotic medication us 11/23/2015 by the Director of The Nurse Practitioner was by the Medical Director rega Long Term Care regulations	on or of the truth of ion set forth on s. The plan is olely because ns of the State hed for ident # 14 istrative of for ers and no ed. The order 6pm today xpired on educated on rventions and e on of Nursing. re-educated arding the	

12/09/2015

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.

**Electronically Signed** 

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/20 FORM APPROVE OMB NO. 0938-039
TATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345051	B. WING		11/19/2015
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE
			405 SOUTH GREENE STREET		
ANSON H	EALTH AND REHABILIT	ATION		WADESBORO, NC 28170	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE COMPLETIO D THE APPROPRIATE DATE
F 222	-	red mental status) most	F 2	regulation regarding unne	-
	stroke " . Discharge 5 mg every 6 hours a On 10/23/15 the Nurs #14 was admitted at The 10/23/15 Nursing " noted increase of a and swinging hands. stated ' I'm OK just II On 10/23/15 at 2 PM Nurse # 5 notified the about the Resident's treatment orders wer On 10/23/15 the 2:15 Resident #14 receive agitation. On 10/23/15 at 3:00 revealed Resident #1 was calm and quiet w Review of the Physic revealed orders for: as needed for agitatic twice a day. On 10/26/15 the Phy Haldol 5 mg was red On 10/27/15 the daily	g Note at 1:55 PM indicated gitation started yelling out Asked what he wants eave me alone ' " . the Nursing Note indicated e Family Nurse Practitioner behavior and Haldol e provided. 5 PM Nursing Note indicated ed Haldol 5 mg by mouth for PM the Nursing Note 14 had his eyes closed and with family members present. ian Orders dated 10/23/15 Haldol 5 mg every 6 hours on an order for Haldol 5 mg sician's Orders revealed the		medications on 11/19/15. Director updated the facil orders to reflect the new psychotropic medication 11/19/2015. The updated that no use of physical or restraints may be used up by the Medical Director, u emergency situation conc safety, and that the reside must be notified prior to th Corrective action for thos having the potential to be An audit was completed th Nursing and Assistant Dir on 11/20/2015 to identify receiving psychotropic me ensure appropriate usage were in place. No other is identified. Measures and Systemic of place An in-service was completed licensed nurses 11/23/20 the Assistant Director of N updated facility standing psychotropic medication	ity standing policy for use on policy states chemical hless approved unless there is an cerning resident ents⊟ family he physician. e residents affected by the Director of rector of Nursing any resident edications and to e and diagnoses ssues were Changes put in eted for all 15 to 12/8/15 by Nursing, on the orders for
	part, " ensure safety agitation and aggress indicate that the phys guidance in handling impairment as neede Review of the Nurse 10/30/15 revealed the resident was concerr not as alert that day	ed 10/29/15 revealed, in by intervening early signs of sive behavior " and further sician should be contacted if residents with cognitive ed. Practitioner Note dated at a family member of the ned that Resident #14 was due to his medications. Plan dated 11/4/15 revealed a		behavior assessment/monitoring/ir licensed nurse that has n in-service will be taken of until the in-service is com administrative nursing sta admit orders and all new clinical meeting to ensure and monitoring of all psyc medications. The Pharma sending a list of all reside	ot completed the if the schedule ipleted. The aff will review all orders daily in the proper use chotropic acy will continue

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/14/2015 APPROVED O. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		E SURVEY IPLETED
		345051	B. WING			11	/19/2015
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ANSON H	EALTH AND REHABILIT	ATION			05 SOUTH GREENE STREET /ADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 222	plan of care for " nee (e.g. refusals of care, combativeness-hitting staff, etc) and depress crying/tearfulness, sa appetite, withdrawal if The goals of care we depressive mood " a effects from psychotr Interventions include ordered ", " discoura , " if he becomes cor leave him safe and a " provide comfort me encourage him to exp and " encourage par activities ". Review of the Nurse History and Physical consult mental health agitation and sun dow On 11/9/15 a Physici Haldol orders were d every 6 hours as nee Review of the Medica (MAR) for 10/23/15 - needed doses were a Scheduled doses of I 10/23/15 - 10/27/15 a On 11/17/15 at 9:50 / indicated Resident # sitting in front of his g noted injury. On 11/17/15 at 10:30 indicated " Resident of agitation. He atter up out from chair ".	eds monitoring of behaviors (medications/treatments, g/kicking, yelling/cursing at isive mood (e.g. ad facial expressions, poor from usual activities, etc.). " re " decreased episodes of and " will not exhibit any side opic medication ". d " administer Haldol as age inappropriate behaviors " mbative/resistive during care ttempt care at a later time ", asures as needed ", " oress/ventilate his feelings " ticipation in out of room Practitioner readmission dated 11/9/15 revealed " oregarding increased whing behavior ". an's Order revealed all iscontinued (Haldol 5 mg eded was then discontinued). ation Administration Record 11/9/15 revealed no as administered to the resident. Haldol were administered as ordered. AM the Nursing Note 14 was found on the floor geri-chair. There was no P AM the Nursing Note continue to display increase mpted multiple times to get The note further indicated an p now and again at 6:00 PM	F	222	Psychoactive medications to the Direc of Nursing ongoing. Any resident identified to be on Psychoactive medications will be reviewed by The administrative nursing team weekly at the Pharmacy consultant monthly to ensure appropriate medication use. A nurse identified as failing to follow the policy regarding Psychoactive medications will be followed up with b Director of Nursing as indicated. This review will be ongoing as long as the resident remains on a Psychoactive medication. Monitoring The daily review of physicians orders, outcomes of the Administrative nursin team review will be presented monthly three months to the Quality Assurance Performance Improvement Committee the Director of Nursing for review and recommendations.	and any y the and g y for	

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		NG	COMPLETED
		345051	B. WING		11/19/2015
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		DE
ANSON H	EALTH AND REHABILIT	ATION		405 SOUTH GREENE STREET WADESBORO, NC 28170	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLE E APPROPRIATE DATE
F 222	Continued From page	93	F 2	222	
	as ordered at 10:30 A				
	On 11/17/15 at 1:30 PM the Nursing Note revealed "Resident constantly attempted to get up out from chair or in the bed. Offered snacks and drinks, staff continue to monitor him ". The note further indicated an order for Ativan 1 mg IM				
		received from the Nurse			
		PM documentation in the			
	and quiet.	ed Resident #14 was calm			
		ed resident #14 was calm			
	According to the MAF #14 received the orde	R dated 11/17/15 Resident ered dose of Haldol 5 mg by			
	mouth at 6:00 PM. On 11/19/15 at 8:48 A	•			
	consulted about the H	ated that he had not been laldol orders for Resident s expectation in future that			
		nust be approved by the			
	there were many othe	ndication. He added that er things than could be done			
	Physician also said th	nd combativeness. The nat just because the resident e acute care hospital setting,			
	•	ppropriate for him in the			
	a restraint to prevent	ions should not be used as residents from getting up.			
	conducted with Nurse	a telephone interview was # 5. She had received the administered Haldol to			
	Resident #14 on both	0/23/15 and 11/17/15. ould not recall the events of			

Facility ID: 952941

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		TE SURVEY MPLETED
		345051	B. WING		1	1/19/2015
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP C		•	
ANSON H	EALTH AND REHABILIT	ATION		05 SOUTH GREENE STREET NADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 222 F 278 SS=D	and stated that the re- with staff after he had swinging his arms an was concerned that h stated that she had s eye on him and offere- it was not effective ar out of his chair or out said that she assesse and did not find any in attempted any pain m his fall. On 11/19/15 at 10:20 was conducted with t stated that the Haldo combative and agitate that were reported to clinical indication was acknowledged not do In addition she said s investigative tests as several days to come calm the resident and next time she was at not consider it a cherr expected the facility s could before calling h 483.20(g) - (j) ASSES ACCURACY/COORD	call the events of 11/17/15 esident had been combative d a fall. He was yelling and d trying to get up and she he would fall again. She taff members keep a closer ed him snacks and fluids but nd he kept trying to get up of the bed. Nurse #5 also ed Resident #14 after his fall njuries but that she had not nanagement strategies after AM a telephone interview he Nurse Practitioner. She I was ordered to treat the ed behaviors of the resident her. She added that the s Delirium although she ocumenting this diagnoses. he had not ordered the results would take e back and the Haldol would d allow her to assess him the the facility. She said she did nical restraint because she staff had tried everything they her. SSMENT DINATION/CERTIFIED st accurately reflect the ust conduct or coordinate h the appropriate	F 222			12/9/15

Facility ID: 952941

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		345051	B. WING			11/	19/2015
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2010
ANSON H	EALTH AND REHABILIT	ATION		405 SOUTH GREENE STREET WADESBORO, NC 28170			
		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	5		278			
1 270	· · · · · · · · · · · · · · · · ·	ust sign and certify that the		270			
	assessment is comple						
	Each individual who o	completes a portion of the					
	assessment must sig	n and certify the accuracy of					
	that portion of the ass	sessment.					
	Under Medicare and	Medicaid, an individual who					
	willfully and knowingly						
	false statement in a re subject to a civil mon						
	-	ssment; or an individual who					
		y causes another individual					
	-	nd false statement in a is subject to a civil money					
	penalty of not more th						
	assessment.						
	Clinical disagreement material and false sta	t does not constitute a atement.					
	This REQUIREMENT	is not met as evidenced					
	Based on medical re	cord review and staff			F 278		
		failed to accurately code			Disclaimer Clause:		
	(Resident # 59) and t	on the Minimum Data Set herapy services			Preparation and or execution of this pl	an	
	(Resident#1) for two	of twenty sampled residents.			does not constitute admission or		
	The findings included	l:			agreement by the Provider of the truth		
	1. Resident #59 was	admitted to the facility			the facts alleged or conclusion set forth the statement of deficiencies. The pla		
	11/18/10 with last rea	-			prepared and or executed solely becau		
	Cumulative diagnosis and anxiety.	s included, in part, dementia			it is required by the provisions of the S and Federal law.		
	Physician orders were	e reviewed and revealed the			Corrective action accomplished for		
	following medications				resident that was affected		
		lligrams (mg) by mouth (po)				1	

Event ID: P8UD11

Facility ID: 952941

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/14/2015 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	
		345051	B. WING			11/	19/2015
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	EALTH AND REHABILIT			40	5 SOUTH GREENE STREET		
		AHON		W	ADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	<ul> <li>Novolin 70/30 (insulir (SQ) every day befor Ambien (hypnotic) 5 or bedtime (hs) for insor</li> <li>An Annual Minimum I indicated Resident #8 Medications received assessment period in days of injections, 7 or antianxiety, antidepre- medication. No hypn as having been receive period.</li> <li>A review of the Medic for July and August 2 received insulin and i diuretic medication se antidepressant medic hypnotic medication se</li> <li>On 11/17/2015 at 4:0 stated she should hav hypnotic for 7 days of oversight.</li> <li>2. Resident #1 was a 7/9/15 with multiple d congenital hydrocept</li> </ul>	<ul> <li>b) 50 mg po qd</li> <li>20 mg po qd</li> <li>20 mg po qd</li> <li>20 mg po qd 9PM</li> <li>b) 10 units subcutaneous</li> <li>e breakfast</li> <li>mg. 1/2 tab per tube at</li> <li>mnia</li> <li>Data Set (MDS) dated 8/5/15</li> <li>59 was cognitively intact.</li> <li>d during the seven day</li> <li>icluded the following: 7</li> <li>days of insulin, 7 days of</li> <li>essant and diuretic</li> <li>otic medication was noted</li> <li>ved during the assessment</li> </ul> eation Administration Record 015 revealed Resident #59 nsulin injections seven days, even days, antianxiety and cation seven days and seven days. 3PM, Administrative staff #2 ve included the Ambien as a f use and it was an admitted to the facility on iagnoses that included nalus.	F 2	78	A modification of the MDS for residen was completed by the MDS Nurse to include accurate coding for hypnotic u and was transmitted to the state datal on 11/17/15. A modification of the MD for resident #1 was completed by the MDS Nurse to include accurate codin indicate the resident was not receiving Physical and Occupational Therapy a was transmitted to the state database 12/8/15. Corrective action for those residents having the potential to be affected A 100% chart audit of Sections N and the MDS audit was completed by the Administrative Nursing Team 11/18/18 through 12/8/15 of all MDS □s complet since November 1st to ensure accura the coding. Any resident requiring a modification completed and transmitted the state database. Measures and Systemic Changes put place The Administrative Nursing Team was in-serviced regarding proper coding techniques for Sections N and O of th MDS, by the Director of Clinical Servi on 12/8/15 and have been able to pro appropriate verbal responses related questions regarding coding of Sectior and O of the MDS. Monitoring An audit of Sections N and O of all MI completed during that period will be completed weekly for four weeks, the charts monthly for 2 months by 2	Ise pase DS g to g to g nd on O of ted cy of such ed to in e ces vide to is N DS's n 10	
	The quarterly MDS da	ated 10/14/15 indicated			members of the Administrative Nursin	g	

Event ID: P8UD11

Facility ID: 952941

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE	ECONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		345051	B. WING		11/19/2015
NAME OF P	ROVIDER OR SUPPLIER	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	
ANSON H	EALTH AND REHABILIT	ATION		105 SOUTH GREENE STREET NADESBORO, NC 28170	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLET
F 278			F 278		n N
	The Special Treatment Programs Section inc	licated Resident #1 was cupational Therapy (OT)		team who did not complete Section and O to ensure that all MDS s completed are coded accurately be they are transmitted to the state da These audits will be presented by Director of Nursing for 3 months to	efore tabase. he
		's orders indicated the ged from OT on 8/31/15 and		Quality Assurance Performance Improvement Committee for review recommendations.	
F 280 SS=D	PM with Administrative she was responsible She stated that Reside ongoing OT and PT at assessment. She reve oversight and that she end dates for both OT 483.20(d)(3), 483.10(		F 280		12/9/15
	incompetent or other incapacitated under t	he laws of the State, to g care and treatment or			
	within 7 days after the comprehensive asses interdisciplinary team physician, a registere for the resident, and disciplines as determ and, to the extent pra the resident, the resid legal representative;	e plan must be developed e completion of the ssment; prepared by an , that includes the attending ed nurse with responsibility other appropriate staff in ined by the resident's needs, acticable, the participation of dent's family or the resident's and periodically reviewed n of qualified persons after			

		D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345051	B. WING		11/19/2015
NAME OF PI	ROVIDER OR SUPPLIER		- <b>-</b> T	STREET ADDRESS, CITY, STATE, ZIP CODE	11/10/2010
ANSON H	EALTH AND REHABILITA	ATION		405 SOUTH GREENE STREET WADESBORO, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 280	Continued From page each assessment.	28	F 2	80	
	by: Based on observation and staff interviews, t and revise a care plan reviewed for range of had bilateral hand spl five sampled resident medications (Resident included: 1. Resident #43 was Cumulative diagnoses A Quarterly Minimum Set) dated 8/5/15 indi short and long term m severely impaired in of Resident required tota of ADL's (activities of limitation in range of m lower extremities was A care plan dated 1/1 8/5/15 stated the follon needed total assistan secondary to quadripl contractures of all ext #43 will not present w development over the included, in part, appl	admitted to facility 11/14/05. s included: quadriplegia Data Set (Minimum Data cated Resident #43 had nemory impairment ad was daily decision-making. al assistance with all areas daily living). Functional notion of the upper and noted. 0/07 and last reviewed wing, in part, Resident #43 ce with ADL tasks		F 280 Disclaimer Clause: Preparation and or execution of this p does not constitute admission or agreement by the Provider of the trutt the facts alleged or conclusion set for the statement of deficiencies. The pla prepared and or executed solely beca it is required by the provisions of the s and Federal law. Corrective action accomplished for resident that was affected The Comprehensive Care Plan for Resident #43 was reviewed by the MI Nurse on 11/18/15 and was updated reflect the discontinuing of the bilaters splints to the hands. The Compreher Care Plan for Resident #14 was revie by the MDS Nurse on 11/18/15 and w updated to reflect the discontinuing of Haldol. Administrative Staff #2 was in-serviced by the Director of Clinical Services on 12/8/15 regarding how to properly document on the care plan for new onsets of conditions and orders a discontinuing interventions and proble as issues are resolved. Corrective Action for Residents With Potential to Be Affected A one hundred percent chard audit w	DS co al sive wed vas f the or and ems The

Event ID: P8UD11

Facility ID: 952941

If continuation sheet Page 9 of 27

	S FOR MEDICARE &				OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345051	B. WING		11/19/2015
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	CODE
ANSON H	EALTH AND REHABILIT	ATION		405 SOUTH GREENE STREET WADESBORO, NC 28170	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE COMPLETIC D THE APPROPRIATE DATE
F 280	Continued From page	9	F 28	30	
	splint use: Resident to prevent further contra- breakdown and impai- hand splint daily. A review of the Nover Administration Record documentation that R observed for skin brea- circulation under his r An observation on 11 Resident #43 lying in contracted position. If that time. An observation on 11 Resident #43 lying in contracted position. If that time. An observation on 11 Resident #43 lying in contracted position. If that time. An observation on 11 Resident #43 lying in contracted position. If that time. On 11/17/2015 at 4:44	ed the following in relation to to wear hand splints to acture. Assess for skin ired circulation under right mber Medication d (MAR) revealed tesident #43 had been akdown and impaired right hand splint daily. /16/15 at 4:00PM revealed bed with both hands in a No splints were in place at /17/15 at 10:51AM revealed bed with both hands in a No splints were in place at /17/15 at 4:30PM revealed bed with both hands in a No splints were in place at /17/15 at 4:30PM revealed bed with both hands in a No splints were in place at /17/15 at 4:30PM revealed bed with both hands in a No splints were in place at		completed by the Adminis Team on 11/23/15 of all re determine which resident be at potential risk for cor splinting and overlooked residents that have been at risk for contractures, sp overlooked orders had the reviewed for appropriate the Care Plan Team on 1° care plans were updated Measures and Systemic O place The Care Plan Team for F #14, the Administrative N and the Administrator wei the Director of Clinical Se 12/8/15 regarding how to document on the care pla of conditions and orders a interventions and other pr issues are resolved. Monitoring The Care Plan Team will Plans weekly for four wee Care Plans monthly for tw to ensure the Care Plans interventions to address r conditions or discontinuin orders and other problem resolved. The Director of	esidents to s are identified to intractures, orders. All identified to be oblinting or eir Care Plan interventions by 1/23/15 and the if indicated. Changes put in Resident #43 & ursing Team, re in-serviced by ervices on properly an for new onsets and discontinuing roblems as review two Care eks and eight vo more months are updated with new onsets of ig interventions, is as issues are
	program. He was dis PROM (passive range program on 4/14/15. received bilateral han discharged from the p his goals of preventio	Resident #43 no longer		present the results of thos Quality Assurance Perfor Improvement Committee three months for review a recommendations.	mance monthly for

CENTERS FOR MEDICARE & MEDICAID SERVICES       STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION     (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A. BUILDING     (X3) DATE SU COMPLET	BURVEY ETED
	9/2015
345051 B. WING 11/19/	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ANSON HEALTH AND REHABILITATION 405 SOUTH GREENE STREET WADESBORO, NC 28170	
(X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE       DEFICIENCY)	(X5) COMPLETION DATE
F 280       Continued From page 10 physician and written a discontinuation order regarding the bilateral splints because they were not benefitting him. She showed documentation of a physician order dated 4/14/15 to discontinue the restorative program for PROM/ bilateral splints         On 1/18/15 at 8:20AM, an interview was conducted with NA #1. She stated she also worked in the restorative nursing program and Resident #43 did not have any hand splints. NA #f siad Resident #43 wore his bilateral hand splints for about six hours/ day prior to the splints being discontinued. She though this splints had been discontinued. She though Resident #43 no longer wore splints, she still checked for redness and skin breakdown and that was what was documented on the MAR.         On 11/18/15 at 8:27AM, Nurse #2 stated, normally, the restorative nurse would inform her when splints were initiated and/or discontinued. She stated there had been a lack of communication and as he should have questioned someone about Resident #43 splints.         On 11/18/2015at 9:44AM, Administrative staff #2 stated order changes were reviewed every day in morning meeting and changes were made at that time to the care plain if needed. She stated it was her understanding they were taking him off the restorative program and nursing was to apply the splints so that why it was still on the care plan. She stated it was probably miscommunication.         On 11/18/2015at 9:434M, Administrative staff #1 stated dre splints should have been removed	

		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345051	B. WING			11/	/19/2015
NAME OF PF	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ANSON HI	EALTH AND REHABILITA	ATION			05 SOUTH GREENE STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	diagnoses including u dementia without beh infarction. The Admission Minim 10/30/15 revealed the impaired, rejected car antipsychotic medicat Review of the Care P plan of care for " nee (e.g. refusals of care// combativeness-hitting staff, etc) and depress crying/tearfulness, sa appetite, withdrawal fi The goals of care wer depressive mood ' ar effects from psychotro Interventions included ordered . On 11/9/15 a Physicia Haldol orders were di On 11/19/15 at 10:05 was interviewed. She	admitted on 10/23/15 with irinary tract infection, aviors and cerebral um Data Set (MDS) dated e resident was cognitively re and had been on ions. lan dated 11/4/15 revealed a ds monitoring of behaviors medications/treatments, i/kicking, yelling/cursing at sive mood (e.g. d facial expressions, poor rom usual activities, etc.). " re " decreased episodes of nd " will not exhibit any side opic medication " . d " administer Haldol as an ' s Order revealed all	F	280			
F 325 SS=D	care plan should have it was an oversight. 483.25(i) MAINTAIN N		F	325			12/9/15
		-					

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		ND HUMAN SERVICES	-		PRINTED: 12/14/207 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345051	B. WING		11/19/2015
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	
		471011		405 SOUTH GREENE STREET	
ANSON H	EALTH AND REHABILIT	ATION		WADESBORO, NC 28170	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 325			F 32	5	
	by: Based on record rew interview, the facility therapeutic diet (doul ordered for 1 (Reside resident on dialysis. Resident # 49 was at 8/8/15 with multiple of stage renal disease ( Minimum Data Set (M 11/4/15 indicated tha cognition and was on The notes of the regi the dialysis clinic wer dated 8/20/15 indicate Resident #49 was 3.2 higher. The RD had portions to help meet prostat (protein supp The facility's dietary in notes indicated that F the RD at the facility notes did not address the dialysis clinic reg portion. The notes d recommended to imp recommendation for	ble portion of meat) as ent #49)of 1 sampled Findings included: dmitted to the facility on liagnoses including end ESRD). The quarterly MDS) assessment dated t Resident #49 had intact t Resident #49 had intact dialysis. stered dietician (RD) from re reviewed. The notes red that the albumin level for 2 (low). The goal was 4 or recommended double meat t protein needs in addition to lement) twice a day. notes were reviewed. The Resident #49 was seen by on 8/26/15 and 9/16/15. The s the recommendation from arding the double meat ated 10/14/15, the RD had blement the dialysis clinic		<ul> <li>F325</li> <li>Disclaimer Clause:</li> <li>Preparation and or execution of the does not constitute admission or agreement by the Provider of the the facts alleged or conclusion se the statement of deficiencies. The prepared and or executed solely he it is required by the provisions of the and Federal law.</li> <li>Corrective action accomplished for resident that was affected</li> <li>The tray card for Resident #49 was updated by the Certified Dietary N (CDM) on 11/18/2015 and the ress now receiving double portions of meats/chicken. The CDM was inand counseled regarding following orders and updated the tray card indicated on 11/24/2015.</li> <li>Corrective action for those resider having the potential to be affected A 100% tray card audit was comp the Certified Dietary Manager on 11/23/2015 through 11/30/2015 to compare the tray cards against the physician orders to ensure the tray</li> </ul>	truth of t forth on e plan is because he State or as Manager ident is serviced g dietary as hts l leted by e

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ATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DA	NO. 0938-03 ATE SURVEY DMPLETED
		345051	B. WING			11/19/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
NSON H	EALTH AND REHABILIT	ATION		405 SOUTH GREENE STREET		
				WADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 325	Continued From page	e 13	F 32	25		
	breakfast and double dinner. " On 11/12/19 double portions of me request. On 11/16/15, the albu- was 3.3 (low). On 11/17/15 at 5:40 F observed during dinn a regular portion of cl not indicate double p On 11/18/15 at 5:40 F observed during dinn a regular portion of h did not indicate doubl On 11/18/15 at 5:43 F was interviewed. She aware that Resident a double portion of me but she was not aware	<ul> <li>meats with lunch and</li> <li>there was an order for eat/chicken per resident's</li> <li>umin level for Resident #49</li> <li>PM, Resident #49 was er time. Her tray contained hicken. Her dietary card did ortion of meat/chicken.</li> <li>PM, Resident #49 was er time. Her tray contained amburger. Her dietary card le portion of meat/chicken.</li> <li>PM, administrative staff #3 e indicated that she was #49 had a doctor's order for at during lunch and dinner re that it was not written on therefore the double meat</li> </ul>		<ul> <li>found to have inaccurate tray can Measures and Systemic Change place</li> <li>A Dietary Order Monitoring Tool y developed by the Director of Clin Services on 12/9/15 to facilitate communication and updating of t cards. The tool will be utilized da morning stand up meeting to ver tray cards are updated as indicat Certified Dietary Manager was in on 12/9/15 by the Administrator r completion of the Dietary Order Monitoring Tool.</li> <li>Monitoring The Certified Dietary Manager w residents with new dietary orders week to ensure the order matche card and the resident is receiving has been ordered. The audits w continue for three months. The O Dietary Manager will present the those audits to the Quality Assur Performance Improvement Comm monthly for three months for revi</li> </ul>	s put in was ical he tray aily in the ify the ed. The -serviced egarding ill audit 3 s per s the tray y what ill certified results of ance nittee	
F 329 SS=D	483.25(I) DRUG REG UNNECESSARY DR	GIMEN IS FREE FROM UGS	F 3:	recommendations 29		12/9/15
	unnecessary drugs. drug when used in ex duplicate therapy); or without adequate mo indications for its use	regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate ; or in the presence of es which indicate the dose discontinued; or any				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/14/2015 / APPROVED ). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345051	B. WING			11/	19/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				4	05 SOUTH GREENE STREET		
ANSON H	EALTH AND REHABILITA	ATION		v	VADESBORO, NC 28170		
		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	х	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 329	Continued From page	2 14	F:	329			
	combinations of the re						
	Based on a comprehe	ensive assessment of a					
	-	nust ensure that residents					
		ntipsychotic drugs are not					
		ess antipsychotic drug					
		to treat a specific condition					
	•	cumented in the clinical					
		who use antipsychotic I dose reductions, and					
	behavioral interventio						
		effort to discontinue these					
	drugs.						
		is not met as evidenced					
	by:	is not met as evidenced					
		ew, staff Nurse Practitioner			F-329		
		w, the facility failed to utilize			Disclaimer Clause:		
		approaches to address			Preparation and or execution of this pla	an	
		aluate the underlying cause			does not constitute admission or		
		fore or during treatment			agreement by the Provider of the truth		
	with antipsychotic me				the facts alleged or conclusion set forth		
	reassess the ongoing				the statement of deficiencies. The plan		
		ion in the absence of a			prepared and or executed solely becau		
		l of 5 sampled residents			it is required by the provisions of the St	ate	
	(Resident #14). The				and Federal law.		
	diagnoses including u	mitted on 10/23/15 with					
	dementia without beh				Corrective action accomplished for		
	infarction.				resident that was affected		
		um Data Set (MDS) dated			The medical record for Resident # 14		
		e resident was cognitively			was reviewed by the administrative		
	impaired, rejected car				nursing team on 11/19/2015 for		
	antipsychotic medicat				appropriate medication orders and no		
		ge Summary dated 10/23/15			other concerns were identified. The ord	ler	

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/14/201 RM APPROVE NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTIO			TE SURVEY MPLETED
		345051	B. WING			1	1/19/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP CODE		
	EALTH AND REHABILIT	ATION	405 SOUTH GREENE STREET				
ANSON II				WADESBORO	), NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC			OULD BE	(X5) COMPLETION DATE
F 329	revealed " On arrival agitated and cannot p after receiving 1 mg	ntinued From page 15 ealed " On arrival the patient is confused and ated and cannot provide any history. Even er receiving 1 mg (milligram) of Ativan		was a one	5mg po now and 6pm e-time order and expired Nurse #5 was reeduca	d on	
	requiring 6 security g hurting himself or the medication) 5 mg IV	on) IV (intravenously) he is uards to prevent him from staff. Haldol (antipsychotic given. " The Discharge ted due to combativeness		assessme antipsycho 11/23/201	ent/monitoring/interventi otic medication use on I5 by the Director of Nu e Practitioner was re-ec	rsing.	
	" which was then red medication that can b disorders) was added	-		Long Term Psychoact regulation	edical Director regarding n Care regulations rega tive medication use and n regarding unnecessar	arding d the y	
	agitation and enceph characterized by alte likely secondary to un	diagnoses included " alopathy (brain malfunction red mental status) most rinary tract infection and		Director up orders to r psychotrop	ons on 11/19/15. The Me updated the facility stand reflect the new policy fo opic medication use on	ding or	
	5 mg every 6 hours a	medications included Haldol is needed for agitation. sing Note indicated Resident 1:24 PM.		that no use restraints	5. The updated policy see of physical or chemic may be used unless ap edical Director, unless the	cal oproved	
	" noted increase of a	g Note at 1:55 PM indicated gitation started yelling out Asked what he wants eave me alone ' "		safety, and must be n	cy situation concerning Id that the residents□ fa notified prior to the phys e action for those reside	amily sician.	
	On 10/23/15 at 2 PM Nurse # 5 notified the about the resident's to treatment orders were	the Nursing Note indicated Family Nurse Practitioner behavior and Haldol e provided.		having the An audit w Nursing ar on 11/20/2	e potential to be affecte was completed by the D ind Assistant Director of 2015 to identify any res	d Director of f Nursing sident	
	Resident #14 receive agitation. On 10/23/15 at 3:00	0		ensure ap were in pla identified.		agnoses ere	
	was calm and quiet w Review of the Physic	4 had his eyes closed and vith family members present. ian Orders dated 10/23/15 Haldol 5 mg every 6 hours		place An in-serv	s and Systemic Change vice was completed for nurses 11/23/2015 to 12	all	
	as needed for agitation twice a day.	on an order for Haldol 5 mg		the Assista updated fa	ant Director of Nursing, acility standing orders fo ppic medication use, and	, on the for	

Event ID: P8UD11

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						MB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		X3) DATE SURVEY COMPLETED
		345051	B. WING			11/19/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, C	CITY, STATE, ZIP CODE	
ANSON H	EALTH AND REHABILIT	ATION		405 SOUTH GREEN		
				WADESBORO, NO	L 2817U	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH (	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE
F 329	Continued From page	2 16	F 32	9		
	Haldol 5 mg was redu		1 02	behavior		
		Haldol was discontinued			monitoring/interventions. Ar	NV VI
	-	nsultation was ordered.			se that has not completed th	-
		ed 10/29/15 revealed, in			ll be taken off the schedule	~
	-	by intervening early signs of			ervice is completed. The	
		sive behavior " and further			e nursing staff will review al	ı
		ician should be contacted if			and all new orders daily in	·
		residents with cognitive			ing to ensure the proper use	e
	impairment as neede				ng of all psychotropic	
		Practitioner Note dated			The Pharmacy will continue	e
	10/30/15 revealed that	at a family member of the			t of all residents on	
	resident was concern	ed that Resident #14 was		Psychoactive	e medications to the Director	r
	not as alert that day c	lue to his medications.			ngoing. Any resident	
	Review of the Care P	lan dated 11/4/15 revealed a		identified to b	pe on Psychoactive	
	plan of care for " nee	eds monitoring of behaviors		medications	will be reviewed by The	
		medications/treatments,		administrativ	e nursing team weekly. The	e
	-	g/kicking, yelling/cursing at		-	onsultant will continue to	
	staff, etc) and depres				sidents□ medications month	nly
		d facial expressions, poor			propriate medication use.	
		rom usual activities, etc.). "		-	entified as failing to follow th	ne
		re "decreased episodes of			ing Psychoactive	
	-	nd " will not exhibit any side			will be followed up with by the	he
	effects from psychotro				ursing as indicated. This	
		d " administer Haldol as			e ongoing as long as the	
		age inappropriate behaviors "			ains on a Psychoactive	
		nbative/resistive during care		medication.		
		tempt care at a later time ",		Monitoring	iow of physicians and are	ad
		asures as needed " ,  " press/ventilate his feelings "			iew of physicians orders, ar	iu
		ticipation in out of room			the Administrative nursing will presented monthly for	
	activities ".				to the Quality Assurance	
		Practitioner readmission			Improvement Committee b	v
		dated 11/9/15 revealed "			of Nursing for review and	3
	consult mental health			recommenda	-	
	agitation and sun dow					
	-	an's Order revealed all				
		scontinued (Haldol 5 mg				
		· •				
		ded was then discontinued).				

Facility ID: 952941

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		ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 12/14/2015 ORM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION	(X3) I	DATE SURVEY COMPLETED
		345051	B. WING				11/19/2015
NAME OF P	ROVIDER OR SUPPLIER	•	•	STF	REET ADDRESS, CITY, STATE, ZIP CODE	•	
	EALTH AND REHABILIT	ATION		405	SOUTH GREENE STREET		
	EALTH AND REHADILIT	AHON		WA	DESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 329	needed doses were a Scheduled doses of H 10/23/15 - 10/27/15 a On 11/17/15 at 9:50 A indicated Resident #1 sitting in front of his g noted injury. On 11/17/15 at 10:30 indicated " Resident of agitation. He atten up out from chair " order for Haldol 5 mg was received from the According to the MAF as ordered at 10:30 A On 11/17/15 at 1:30 F revealed " Resident of up out from chair or in and drinks, staff conti note further indicated (intramuscularly) was Practitioner. Accordin medication was giver On 11/17/15 at 3:00 F Nursing Note indicate and quiet. On 11/17/15 at 6:00 F Nursing Note indicate and quiet in bed. According to the MAF #14 received the order mouth at 6:00 PM. On 11/19/15 at 8:48 A interviewed. He indic consulted about the F #14 and that it was hit	11/9/15 revealed no as administered to the resident. Haldol were administered as ordered. AM the Nursing Note 14 was found on the floor geri-chair. There was no AM the Nursing Note continue to display increase inpted multiple times to get The note further indicated an now and again at 6:00 PM e Nurse Practitioner. R the medication was given AM. PM the Nursing Note constantly attempted to get in the bed. Offered snacks inue to monitor him " . The an order for Ativan 1 mg IM a received from the Nurse ing to the MAR the n as ordered. PM documentation in the ed Resident #14 was calm PM documentation in the ed resident #14 was calm R dated 11/17/15 Resident ered dose of Haldol 5 mg by AM the Physician was cated that he had not been Haldol orders for Resident is expectation in future that must be approved by the	F	329			

Facility ID: 952941

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	S FOR MEDICARE &				OMB NO. 0938-
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345051	B. WING		11/19/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE
ANSON HI	EALTH AND REHABILIT	ATION		405 SOUTH GREENE STREET WADESBORO, NC 28170	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLE THE APPROPRIATE DATE
F 329	Continued From page	e 18	F 3	29	
		ndication. He added that			
	there were many other things than could be done				
	-	ind combativeness. The			
		nat just because the resident			
	-	acute care hospital setting,			
		ppropriate for him in the			
	facility that was his ho				
		ions should not be used as residents from getting up.			
	•	a telephone interview was			
		# 5. She had received the			
	orders for Haldol, and	administered Haldol to			
	Resident #14 on both	10/23/15 and 11/17/15.			
		ould not recall the events of			
		call the events of 11/17/15			
		sident had been combative			
		l a fall. He was yelling and			
		d trying to get up and she e would fall again. She			
		taff members keep a closer			
		ed him snacks and fluids but			
	-	id he kept trying to get up			
	out of his chair or out	of the bed. Nurse #5 also			
		ed Resident #14 after his fall			
	attempted any pain m	njuries but that she had not nanagement strategies after			
	his fall.	AM a talanhana intanyiaw			
		AM a telephone interview he Nurse Practitioner. She			
		was ordered to treat the			
		ed behaviors of the resident			
	•	her. She added that the			
		Delirium although she			
	-	cumenting this diagnoses.			
	In addition she said s				
	-	the results would take			
	several days to come	back and the Haldol would			
	colm the resident and	l allow her to assess him the			

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUU TIOU	E CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED		
		345051	B. WING		11/19/2015		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ANSON H	EALTH AND REHABILIT	ATION		405 SOUTH GREENE STREET WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE		
F 329	Continued From page	e 19	F 329				
		nical restraint because she staff had tried everything they er.					
F 332 SS=D		OF MEDICATION ERROR	F 332	2	12/9/15		
	The facility must ensumedication error rates	ure that it is free of s of five percent or greater.					
	by: Based on record revi interview, the facility f medication error rate administering the medication as ordere opportunities for error rate. Findings include The facility's policy or medications through September, 2014 was in part " do not mix m administering through Administer each med 1a. On 11/18/15 at 8: observed during the m was observed to prep Resident #8 including hypertension), Hydrod hypertension), Tylend (vitamin). Nurse #4 w medications, mixed th	was 5% or below by not dications via gastrostomy e and by not administering a d. There were 2 errors of 26 r resulting in a 7.69 % error ed: n " administering an enteral tube " dated s reviewed. The policy read nedications together prior to n an enteral tube.		F332 Disclaimer Clause: Preparation and or execution of this pl does not constitute admission or agreement by the Provider of the truth the facts alleged or conclusion set fort the statement of deficiencies. The pla prepared and or executed solely beca it is required by the provisions of the S and Federal law. Corrective action accomplished for resident that was affected Nurse #4 was re-educated on 11/23/2 by Assistant Director of Nursing on the CMS guidelines for no longer administering Cocktail style medication via g-tube. Nurse #4 was also watche on a med pass by the ADON to verify proper administration of G-tube meds 11/23/2015 prior to returning to the floo Order for Enteric coated Aspirin qd pe g-tube was clarified on 11/18/2015 and changed to Aspirin 325 mg via peg tut qd by the Unit Manager.	of h on n is use state 015 e ns ed on or. r d		

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				E CONSTRUCTION	OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345051	B. WING		11/19/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
ANSON H	EALTH AND REHABILIT	ATION		405 SOUTH GREENE STREET WADESBORO, NC 28170	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 332			F 33	2	
	proceeded to flush the G tube with water and poured the medications from the medication cup into the G tube.			Corrective action for those having the potential to be a The medications of all resid medications via G-tube we the Administrative Nursing	affected dents receiving re audited by
	facility and was not tr medications via G tul not know that each m	ted that she was new to the rained on how to administer be. She added that she did		the Administrative Nursing 11/19/2015 through 12/8/20 the medications could be c administered via G-tube. If forms of medications were physician was notified and	015 to ensure rrushed to be f non crushable identified, the the orders
	was interviewed. She	12:35 PM, administrative staff #1 . She stated that she expected Iminister medications via G tube		were changed to appropria (crushable or liquid) of med indicated. Measures and Systemic Cl place All other nurses were re-ec	dications as hanges put in
	6/13/14 for enteric co and prevents blood c	blet per tube daily. *Do not		proper administration of g-1 medications and order clar medications for g-tube resi cannot be crushed beginni 11/23/2015 by the ADON a on 12/9/2015. All new nurs	tube ifications of dents that ng on ind completed
	observed during the i was observed to prep Resident #8 including hypertension), Hydro hypertension), Tylend	medication pass. Nurse #4 pare the medications for g Amlodipine (drug for chlorothiazide (drug for ol (analgesic) and Certavite		this information in the new Pharmacy med pass audits the Facility Pharmacy cons random med pass observa done by Administrative nur	hire orientation. s to be done by sultant and tions to be ses will be
	the enteric coated as was observed to adm			completed to ensure comp policy on g-tube medication administration. All new administration. All new orders new orders including g-tub have orders reviewed, veri clarified as needed for prop	n nissions and e residents will fied and/or
	administer the ECAS that it should not be of have the regular aspi	A because the order stated crushed and she did not irin in her medication cart. octor should have been		route/form of administration clinical meetings. Monitoring Pharmacy med pass audits the Facility Pharmacy cons	n during daily s to be done by

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/14/2015 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	
		345051	B. WING			11/	/19/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
				40	05 SOUTH GREENE STREET		
ANSON H	EALTH AND REHABILIT	ATION		W	ADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 332	Medication Administra nurse's initials indicat administered ECASA On 11/19/15 at 12:35 was interviewed. She ECASA should have 483.30(e) POSTED N INFORMATION The facility must post a daily basis: o Facility name. o The facility name. o The current date. o The total number at by the following categ unlicensed nursing st resident care per shiff - Registered nurs - Licensed practic vocational nurses (as - Certified nurse at o Resident census. The facility must post specified above on a of each shift. Data m o Clear and readable o In a prominent plac residents and visitors The facility must, upo	ation Records (MARs) had ing that they had to Resident #8 via G tube. PM, administrative staff #1 e stated that the order for been verified with the doctor. NURSE STAFFING The following information on and the actual hours worked gories of licensed and aff directly responsible for t: es. cal nurses or licensed a defined under State law). aides. The nurse staffing data daily basis at the beginning just be posted as follows: format. e readily accessible to		332	done by Administrative nurses to ensu compliance with policy on g-tube medication administration. The med-p audits will be completed on at least 2 nurses on varied shifts and at least or weekend shift weekly for 4 weeks, the monthly for 2 months. The results of those audits will be presented by the Director of Nursing monthly for 3 mon in the Quality Assurance Performance Improvement Committee meeting for review and recommendations.	bass le n ths	12/9/15

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/201 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345051	B. WING		11/19/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· · ·
ANSON H	EALTH AND REHABILIT	ATION		405 SOUTH GREENE STREET	
				WADESBORO, NC 28170	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 356	Continued From page	e 22	F 35	56	
		ot to exceed the community			
	staffing data for a mir	ntain the posted daily nurse nimum of 18 months, or as , whichever is greater.			
	by: Based on observation facility failed to post to data. The findings in A tour of the facility we 10:30 AM. The poster indicated it was for 1° staffing data posted for An interview was com Administrator on 11/1 revealed that she was data posting was not 11/15/15 or on the me stated that she expect	vas conducted on 11/16/15 at ed nurse staffing data 1/13/15. There was no nurse for 11/16/15. Inducted with the 17/15 at 3:15 PM. She s unaware the nurse staffing updated on 11/14/15, orning of 11/16/15. She		<ul> <li>F356</li> <li>Corrective action accomplished for resident that was affected</li> <li>The daily staff posting was correct posted the RN Unit Manager on 11/16/2015 when it was brought to facility s attention by the surveyor resident was found to be affected deficient practice.</li> <li>Corrective action for those resident having the potential to be affected offected by the deficient practice.</li> <li>No resident was found to be potential to be affected by the deficient practice.</li> <li>Posting of the Daily Staffing Form been assigned the responsibility to Receptionist which are present set days a week. Any staff member to be responsible for posting the Daily Staffing form was in-serviced by the Department Heads that serve as a no Duty on the weekends were in-serviced by the Assistant Direct Nursing on 12/9/15 regarding the requirement for posting the Daily</li> </ul>	etted and o the pr. No by the nts d ntially s put in n has to the even that may ily the 12/9/15 sting the e Manager tor of

Event ID: P8UD11

Facility ID: 952941

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/14/2015 // APPROVED ). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345051	B. WING			11/	19/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				40	5 SOUTH GREENE STREET		
ANSON H	EALTH AND REHABILITA	ATION		W	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 356 F 514 SS=B	LE The facility must main resident in accordanc standards and practic accurately documente systematically organiz The clinical record mu information to identify resident's assessmen services provided; the preadmission screeni and progress notes.	TE/ACCURATE/ACCESSIB ntain clinical records on each e with accepted professional les that are complete; ed; readily accessible; and zed. ust contain sufficient the resident; a record of the tts; the plan of care and	F 3	514	form each day and regarding their responsibility for checking to ensure the sheet is posted. Monitoring The Administrator or the Director of Nursing will audit the Daily Staffing form Monday through Friday and the Department Head assigned to Manage on Duty detail Saturday and Sunday, di for one week, then weekly for three weeks, and then monthly for two month to ensure the Daily Staffing Form is posted each day. The Administrator wil present the results of those audits to th Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations.	n r aily IS	12/9/15

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		MEDICAID SERVICES					O. 0938-03
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         345051			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			11/19/2015		
NAME OF PROVIDER OR SUPPLIER				ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
ANSON HEALTH AND REHABILITATION				405 SOUTH GREENE STREET WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 514	Continued From page	e 24	F 51	14			
	Based on observation, medical record review				F514		
		he facility failed to maintain			Disclaimer Clause:		
	complete and accura			Preparation and or execution of this p	lan		
	two residents reviewe			does not constitute admission or			
	(Resident #43) by no			agreement by the Provider of the truth	of		
	order for hand splints			the facts alleged or conclusion set for	h on		
	Treatment Administra	ition Record (TAR) when a			the statement of deficiencies. The pla	ın is	
	physician's order to d			prepared and or executed solely beca	use		
	written in April, 2015.	The findings included:			it is required by the provisions of the S and Federal law.	State	
	Resident #43 was ad	mitted to the facility					
	11/14/05. Cumulative	e diagnoses included:			Corrective action accomplished for		
	quadriplegia				resident that was affected		
					The Care Plan was corrected and		
	A Quarterly Minimum	Data Set (MDS) dated			updated by the MDS Nurse on 11/18/	15	
	8/5/15 indicated Resi			for resident #43. An order was obtain			
	term memory impairn			on 11/18/15 to discontinue use of han			
	impaired in daily deci			splints and the monitoring of skin relat	ed		
	assistance was requi			to use of hand splints.			
		tion occurred, locomotion on					
		sing, eating, toilet use,			Corrective action for those residents		
	personal hygiene and				having the potential to be affected		
		motion of the upper and			An audit was completed on 11/18/15 t		
		s documented during the			11/23/15 by the Administrative Nursing	-	
	seven day assessme	ni penuu.			Team of all current residents in facility receiving restorative nursing services		
	A Care Plan dated 1/	10/07 and last reviewed on			ensure care plans and physician s or		
		owing: Resident #43 needs			were accurate and updated if indicate		
		ADL (activities of daily living)			An in service was completed on 11/18		
		quadriplegia with severe			to 12/9/15 by the Assistant Director of		
		tremities. Goal: Resident			Nursing for all licensed nurses regard		
		with any further contracture			second nurse is required to verify all n		
		e next review. Approaches			admission orders, monthly Medication		
	-	ly left hand splint as ordered			Administration Records (MAR), and		
		hand splint as ordered			Treatment Administration Records (TA	AR).	
	(2/24/15).	-			Both licensed nurses must review the	-	
					resident□s Medical Record for new ar	nd	
	Physician orders for I	November 2015 were			discontinued orders to ensure all curre	ent	
	reviewed and reveale	ed the following: 7/1/14			medications and treatments are		

Facility ID: 952941

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CENTERS FOR MEDICARE & MEDICAID SERVICES		(X2) MULTIPL	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345051				A. BUILDING		
		B. WING		11/19/2015		
NAME OF PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ANSON HI	EALTH AND REHABILIT	ATION		405 SOUTH GREENE STREET NADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOL TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		HOULD BE COMPLETION	
F 514	Continued From page	e 25	F 514			
	Resident to wear hand splints to prevent further contracture. 10/01/14 Assess for skin breakdown and impaired circulation under right hand splint			transcribed accurately on the re MARs and TARs.	dent⊡s	
	daily.	<u>J</u>		Measures and Systemic Change place	es put in	
	for skin breakdown ar under the right hand s splints was also noted information) An observation on 11 Resident #43 with bill position. No splints v	d (MAR) revealed he skin had been assessed nd impaired circulation splint daily. Bilateral hand		Two licensed nurses will verify a admission orders, monthly Medi Administration Records (MAR), Treatment Administration Records both licensed nurses will review resident □s Medical Record for r discontinued orders to ensure a medications and treatments are transcribed accurately on the re MARs and TARs. The administration rursing team will review all new orders and daily orders in clinication compliance	cation and ds (TAR). the new and I current sident s ative admission al meeting	
	Resident #43 in bed	with hands in a contracted vere in place at that time.		Monitoring The administrative nursing team		
	Resident #43 in bed y position. No splints w On 11/17/2015 at 4:4 was in charge of the r stated Resident #43 y restorative program b program. He was dis PROM/ splinting prog continued not to mee from the program and any of his extremities notified the physician	out no longer was in the charged from restorative		all new admission orders and da daily, in the clinical meeting, ong ensure all current medications a treatments are transcribed accu the resident s MARs and TARs ensure continued compliance. If the daily review of physicians outcomes of the Administrative team review will be presented m the Director of Nursing for three the Quality Assurance Performa Improvement Committee for rev recommendations.	aily orders, going, to nd rately on and Results of orders and hursing tonthly by months to nce	

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/14/2015 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345051	B. WING				11/	19/2015
NAME OF PROVIDER OR SUPPLIER			•		STREET ADDRESS, CITY, STA		-	
ANSON HEALTH AND REHABILITATION			405 SOUTH GREENE STREET WADESBORO, NC 28170					
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES					PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		COMPLETION DATE
F 514	<ul> <li>4 Continued From page 26</li> <li>#43 had not had any hand splints since April,</li> <li>2015. She stated she signed on the MAR that she was checking for skin redness and</li> </ul>		F	514				
		at the splints were there.						
		ted the skin even though he						
	no longer had hand s	piints.						
		4AM, Nurse #1 stated she,						
	the MDS nurse and therapy met weekly and, on 4/14/15, had determined that the bilateral hand							
	splints were not benefitting Resident #43. She							
	stated she wrote the discontinuation order at that							
	time and did not know why the orders for the splints continued to be on the physician orders							
	and MAR. She stated discontinuing them.	she just must have missed						
	On 11/18/2015 at 9:49AM, Administrative staff #1							
	stated she had been in the facility about 3 months. She stated the monthly orders were							
	verified by two nurses and they checked the							
	current physician orde	ers and MAR with the two nurses then signed off						
	they had verified the	orders. She stated either						
		ontinued on the May orders						
	or both nurses simply expected the order sh							
	discontinued on the M	/lay orders/ MAR.						
		ated the orders and MAR acy. All orders were faxed						
	to the pharmacy and	they should have also						
	caught it and disconti	nued the order.						

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