PRINTED: 07/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345166	B. WING		05/27/2016
	ROVIDER OR SUPPLIER COUNTY NURSING HOM	E		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	
(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 COMPLETION
F 272 SS=E	ASSESSMENTS The facility must conda comprehensive, acreproducible assessing functional capacity. A facility must make a assessment of a resident assessment by the State. The assesst the following: Identification and der Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior per Psychosocial well-bee Physical functioning a Continence; Disease diagnosis and Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of sunthe additional assession areas triggered by the Data Set (MDS); and Documentation of particulars.	duct initially and periodically curate, standardized nent of each resident's a comprehensive dent's needs, using the instrument (RAI) specified sessment must include at mographic information; atterns; ing; and structural problems; and health conditions; I status;	F 27	TITLE	7/2/16 (X6) DATE

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

(X6) DATE

06/23/2016 **Electronically Signed**

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	(X3) DATE SURVEY COMPLETED		
		345166	B. WING		05/27/2016
	ROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 272	Continued From pag	ge 1	F 272	2	
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to comprehensively assess the needs of a resident related to a diagnosis of depression and use of an antidepressant for 1 of 5 residents reviewed for unnecessary medications (Resident #38); and, failed to comprehensively assess the use of bed rails coded as a physical restraint on the Minimum Data Set (MDS) assessment for 11 of 13 residents reviewed for Comprehensive MDS assessment (Residents #38, #10, #41, #11, #2, #16, #3, #14, #15, and #26). The findings included: 1) Resident #38 was admitted on 4/1/16 from another nursing facility with a cumulative diagnoses which included depression. The resident 's admission medication orders dated 4/1/16 included 37.5 milligrams Effexor (an antidepressant) to be given as one tablet every morning for depression. Resident #38's Nursing Assessment Summary dated 4/6/16 included the following, in part: "Effexor daily for depression." A review of Resident #38's admission MDS (Minimum Data Set) assessment dated 4/8/16 revealed the resident was assessed to have severely impaired cognitive skills for daily			Corrective action to be accomplished the resident found to be affected by the deficient practice: Resident #38- On May 25, 2016, the assessment was updated by the MDS nurse to include the active diagnosis of depression and the use of antidepressmedication was coded. The care area assessment and care plan were then completed to address the use and monitoring of an antidepressant for depression.	of sant
				Residents #38, #10, #41, #11, #2, #16 #3, #14, #15, #26 were assessed individually by the MDS nurse as to whether or not the bed rails were a physical restraint. The form Evaluation use of Side Rails was selected as a to help guide the assessments and the questions from the sample form were used from May 30, 2016 to June 2, 20 to complete the assessments. This form guides assessment for side rail use by prompting answers to how and why signals are being considered for the individual resident and ending with recommendations to use or not use signals, if side rails are indicated, which and timing for the resident. It also prompts the person completing the assessment to answer if the side rails.	on for cool to 016 orm y ide ide type
	staff for all of his Act	e was totally dependent on tivities of Daily Living (ADLs). S assessment (Section I) did dent had an active diagnosis ion N of the MDS		impede the resident □s freedom of movement. On 6/2/16, Section P of tl MDS Assessment was updated to ren the coding of bedrails as a physical	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345166	B. WING _			05/:	27/2016
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
0701/50 /		_		1	570 NC 8 AND 89 HIGHWAY		
STOKES	COUNTY NURSING HOM	E		D	ANBURY, NC 27016		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	Continued From page assessment did not in an antidepressant me	ndicate the resident received	F:	272	restraint and the care area assessment summary was updated for Residents #	38,	
	the care area for Psyd trigger for further revirecord did not include the diagnosis of depre antidepressant medic	y dated 4/11/16 revealed chotropic Drug Use did not ew. The resident 's medical an assessment related to ession or use of an ation.			#10, #41, #11, #2, #16, #3, #14, #15, # This removed the care area trigger #18 Physical Restraints for Residents #38, #10, #41, #11, #2, #16, #3, #14, #15, # The care plans for Residents #38, #10, #41, #11, #2, #16, #3, #14, #15, #26 w updated to discontinue physical restrain with the notation that read Side rails ar used to define parameters of bed and assist with bed mobility remaining on the care plan.	26. ere nts e	
	revealed neither the cand/or the use of an awas addressed for Reaman and an interview was con AM with the MDS nur reported she also assumering Director of Nu and review of the Resassessment, the MDS the diagnosis of depresant medical stated the diagnosis of been included as an awas and the MDS assumers.	diagnosis of depression antidepressant medication esident #38. ducted on 5/26/16 at 10:00 se. The MDS nurse sumed responsibilities as the rsing (DON). Upon inquiry sident #38 's MDS nurse confirmed neither ession nor use of an ation was coded. She of depression should have active diagnosis for Resident sessment should also have an antidepressant. The			Corrective actions to be accomplished residents having potential to be affecte by the same deficient practice: Assessments for all residents on psychotropic medications (to include antidepressants) were reviewed to veri an active diagnosis and coding for medication. All residents were found to have an active diagnosis for psychotropic medications (to include antidepressant and the use of antidepressant medicati was coded. The care area assessmen and care plan addressed the use and monitoring of an antidepressant for depression.	fy o oic s) on	
	antidepressant was n MDS, the topic of psy (which included an ar for the resident. Subsassessment and care address the use and antidepressant for de MDS nurse indicated	ot coded correctly on the chotropic medications ntidepressant) did not trigger sequently, a care area plan were not completed to			Each resident in the facility was assess individually by the MDS nurse as to whether or not the bed rails were a physical restraint. The form Evaluation use of Side Rails was selected as a too help guide the assessments and the questions from the sample form were used from May 30, 2016 to June 2, 201 to complete the assessments. This for	n for ol to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		
0701/50	SOUNTY NUIDONIO LION			1570 NC 8 AND 89 HIGHWAY		
STOKES	COUNTY NURSING HOM	E		DANBURY, NC 27016		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 272	Continued From page	e 3	F 2	72		
	planned for the use o	f an antidepressant		guides assessment for side ra	ail use by	
	medication used to tr	•		prompting answers to how and	-	
		·		rails are being considered for	-	
	2) Resident #38 was	admitted to the facility on		individual resident and ending	ı with	
	4/1/16 from another r			recommendations to use or no		
		s which included a history of		rails, if side rails are indicated	• •	
	cerebrovascular accid	dent (stroke).		and timing for the resident. It		
				prompts the person completin	-	
		sing Assessment Summary		assessment to answer if the s		
		the following, in part: "He		impede the resident ☐s freedo		
		d every 2 hours and (as sused for all transfers. Gets		movement. On 6/2/16, Section MDS Assessment was update		
		ir as tolerated. He is unable		the coding of bedrails as a ph		
	_	otation was included in the		restraint and the care area as		
		Summary in regards to the		summary was updated for all		
	use of bed rails on Re			residents. This removed the	-	
				trigger #18 Physical Restraints	s for all	
	A review of Resident	#38 's admission MDS		Residents. The care plans for	r all	
	(Minimum Data Set) a	assessment dated 4/8/16		Residents were updated to dis	scontinue	
	revealed the resident	was assessed to have		physical restraints with the no	tation that	
	severely impaired cog			read Side rails are used to de	-	
	_	was totally dependent on		parameters of bed and assist		
		vities of Daily Living (ADLs), /. Section P of the MDS		mobility remaining on the care	e plan.	
		d bed rails were a physical		Measures to be put in place o	•	
		ent; and, the bed rails were		changes made to ensure that	the deficient	
	•	/ of the MDS assessment		practice will not occur:		
	•	estraints triggered for the		The MDS nurse and consultar		
		mark indicated this would		pharmacist will complete the a		
		care plan. The Care Area		for all active diagnoses and ps	•	
		ry dated 4/11/16 included a		medications (to include antide on admission. These will be o		
		" Side rails are used to bed and assist with bed		the care area assessment and		
		#38 's medical record did		addressing the use and monit		
	_	sment related to the use of		medications. The consultant		
	bed rails as a physica			maintains patient specific lists		
	Dod rano do a priyolog	ar rootanit.		psychoactive medications whi		
	A review of Resident	#38 's care plan revealed		shared with the MDS nurse.		
		v Incontinence/Pressure				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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				1570 NC 8 AND 89 HIGHWAY			
STOKES	COUNTY NURSING HO	DME		DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 272	Continued From pa	age 4	F 2	72			
	-	traint was initiated on 4/11/16.		The MDS nurse reviewed gu			
	AM with Nurse #3. assigned to care for interview, the nurse used on both sides reported the reside of bed on his own.	onducted on 5/24/16 at 11:42 Nurse #3 was the hall nurse or Resident #38. During the ereported ½ side rails were of the resident 's bed. She not could not physically get out onducted on 5/26/16 at 11:05		understanding of proper cod rails as part of the comprehe assessment with the individu assessments of all residents nurse and all facility nurses training regarding assessme rails for residents and the ne reassessment with change of the training includes educate	ling for side ensive ual s. The MDS will complete ent for side sed for of condition.		
	An interview was conducted on 5/26/16 at 11:05 AM with the MDS nurse. The MDS nurse reported she also assumed responsibilities as the Interim Director of Nursing (DON). The MDS nurse reviewed Resident #38 's section P of the MDS assessment. When asked how it was determined whether or not the resident had a physical restraint, the MDS nurse reported a "physical restraint" assessment form was not used to aid in the assessment of residents or to determine whether or not the bed rails were a physical restraint. The MDS nurse stated she had been trained to code bed rails (when used) as a physical restraint. She reported bed rails were used for all residents in the facility and all			assessment for the use of si the Evaluation for Use of Sic and when side rails would be a restraint. This training will by July 15, 2016.	de rails with de Rails form e considered		
				Each facility resident will be individually by the MDS nurs as to whether or not the bed physical restraint. The MDS designee will utilize the form for Use of Side Rails on adm quarterly or sooner if there is change in condition. The for	se or designee rails are a some nurse or Evaluation and so a significant rm Evaluation		
	nurse then stated, She reported the C Summary (Section bed rails were only with positioning. T "This is a restraint- A follow-up intervie at 10:58 with the M interview, the nurse the facility utilized 3 the side rails were	nysical restraint. However, the "But it really isn't a restraint." Tare Area Assessment V of the MDS) indicated the used to help Resident #38 the MDS nurse also stated, free facility." w was conducted on 5/27/16 IDS nurse. During the ereiterated that all residents in 2/2 side rails on both sides and always coded as a physical IDS assessment. The nurse		for use of Side Rails was sel tool to help guide the assess regarding side rail use. This assessment for side rail use answers to how and why sid being considered for the indiresident and ending with recommendations to use or rails, if side rails are indicate and timing for the resident. prompts the person completi assessment to answer if the impede the resident seed movement.	sments form guides by prompting le rails are ividual not use side ld, which type It also ing the side rail will		

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` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	ı	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		00/2//2010	
		_		1570 NC 8 AND 89 HIGHWAY			
STOKES	COUNTY NURSING HOM	E		DANBURY, NC 27016			
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F 272	Upon inquiry, the MD #38 could not physical own. However, she a assessment had not determine whether or physical restraint. 3) Resident #10 was 1/28/13 from a hospit diagnoses which included have a sessment (Section bed rails were a physical were and the MDS assessment Restraints triggered for this would be included Area Assessment Su which read, "Bed rabed." A review of R revealed the following 11/19/15: Urinary Included The inc	these aren't restraints." So nurse confirmed Resident ally get out of bed on his also indicated an been completed to root the bed rails were a admitted to the facility on tal with a cumulative uded dementia. Al Minimum Data Set (MDS) P) dated 11/18/15 indicated sical restraint for the resident; are used daily. Section V of the indicated Physical for the resident and indicated do in her care plan. The Care mmary included a notation alls to define parameter of the esident #10's care plan go problem was initiated on continence/Pressure aint. A review of Resident sement Summary dated the following notations, in particulated and she is turned and the following notations, in particulated and she is turned and the following notations, in particulated in the assessment. #10's quarterly Minimum	F 27	,	stained: been on next rify that all corded for (to include will be lary team will be Quality of QI or to ensure and been on ments and dition This present at ing. Any at that id reported and any for one been		
	cognitive skills for da	had severely impaired ily decision making. She it on staff for all of her ng (ADLs), with the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP COD 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	•	
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F 272	Section P of the MDS rails were a physical and, the bed rails we the MDS assessmen Restraints triggered f mark indicated this w care plan. A review of (initiated on 11/19/15 Urinary Incontinence Restraint was continus Nursing Assessmen to address the use of medical record did no related to the use of restraint. An interview was contained and the contained to the use of the contained and	g supervision only for eating. S assessment indicated bed restraint for the resident; re used daily. Section V of t indicated Physical for the resident and a check rould be addressed in her of Resident #10's care plan revealed the problem of Pressure Ulcer/Physical and on 5/4/16. The resident 'nt Summary dated 5/4/16 did of bed rails. Resident #10's of include an assessment oped rails as a physical adducted on 5/24/16 at 11:42 durse #3 was the hall nurse Resident #10. During the	F 27	72		
	used on both sides or reported the resident of bed on her own. An interview was con AM with the MDS nur reported she also assenterim Director of Nunurse reviewed Resides MDS assessment. With determined whether ophysical restraint, the "physical restraint" as used to aid in the assed to aid in the assed termine whether ophysical restraint. The had been trained to consider the resident of the second of the resident of the second of the resident of the residen	eported ½ side rails were f the resident 's bed. She could not physically get out ducted on 5/26/16 at 11:05 rse. The MDS nurse sumed responsibilities as the ursing (DON). The MDS dent #10 's section P of the When asked how it was for not the resident had a sessment form was not residents or to residents or to residents or to resident had a resement of residents or to residents or to residents were a resident had see MDS nurse stated she reded bed rails (when used) at the She reported bed rails				

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	ROVIDER OR SUPPLIER	1E		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016			
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F 272	Continued From pag were used for all resivere coded as a phy nurse then stated, "E The MDS nurse also restraint-free facility." A follow-up interview at 10:58 with the MD interview, the nurse of the facility utilized 1/2 the side rails were all restraint on the MDS stated, "Technically Upon inquiry, the MD #10 could not physicown. However, she assessment had not determine whether ophysical restraint. 4) Resident #41 was 11/24/15 from another cumulative diagnose cerebrovascular acciding the most of the resident services.	dents in the facility and all sical restraint. However, the but it really isn't a restraint." stated, "This is a " was conducted on 5/27/16 S nurse. During the reiterated that all residents in side rails on both sides and ways coded as a physical assessment. The nurse, these aren't restraints. " OS nurse confirmed Resident ally get out of bed on her also indicated an been completed to r not the bed rails were a admitted to the facility on er nursing facility with a s which included a history of	F 2	DEFICIENCY)			
	the resident had several for daily decision madependent on staff for Living (ADLs), included of the MDS assessmant a physical restraint for ails were used daily Assessment Summan assessment indicate triggered for the residuals.	erely impaired cognitive skills king. She was totally or all of her Activities of Daily ing bed mobility. Section P ent indicated bed rails were or the resident; and, the bed . Section V (Care Area ry or CAA) of the MDS d Physical Restraints dent and a check mark be addressed in her care					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER COUNTY NURSING HO	ME	15	REET ADDRESS, CITY, STATE, ZIP CODE 70 NC 8 AND 89 HIGHWAY ANBURY, NC 27016	
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F 272	plan. A narrative or follows: "Side rails parameters of bed a Resident #41's me an assessment rela a physical restraint. A review of Residen Summary dated 4/2 part: "Left sided part: "The summary did not accord to the problem of Falls initiated on 4/21/16. An interview was condaminated and the problem of Falls initiated on 4/21/16. An interview was condaminated to care for interview, the nurse used on both sides reported the resider of bed on her own. An interview was condaminated and with the MDS nurse reviewed Resider of Sassessment. Interview we have a linterim Director of Normal Parket Physical restraint, the side of the sassessment. Interview we have the physical restraint, the same and the	the CAA Summary read as are used to define and assist with bed mobility. "dical record did not include ted to the use of bed rails as t #41's Nursing Assessment 0/16 included the following, in aralysis noted due to CVA. Total care for all ADL's exple assist for all lifts, turns e Nursing Assessment ldress the use of bed rails. t #41's care plan revealed //Physical Restraints was	F 272		

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F 272	had been trained to as a physical restrain were used for all rest were coded as a ph nurse then stated, "The MDS nurse also restraint-free facility A follow-up interview at 10:58 with the MI interview, the nurse the facility utilized 1/2 the side rails were a restraint on the MDS stated, "Technically Upon inquiry, the M #41 could not physic own. However, she assessment had no determine whether ophysical restraint. 5) Resident #11 was 8/1/11 from another. The resident 's ann assessment (Section bed rails were a phy and, the bed rails were a phy and, the bed rails were a phy and, the Care Area Assenotation which read parameters of the b #11 's care plan (infollowing problem with the medical state of the colling of the colling of the billing of the colling of the billing of the colling of the billing of t	code bed rails (when used) nt. She reported bed rails sidents in the facility and all sysical restraint. However, the But it really isn't a restraint." o stated, "This is a ." was conducted on 5/27/16 DS nurse. During the reiterated that all residents in side rails on both sides and lways coded as a physical S assessment. The nurse w, these aren't restraints." DS nurse confirmed Resident cally get out of bed on her also indicated an t been completed to or not the bed rails were a	F 272			

, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 272		e 10 #11 ' s quarterly Minimum essment dated 5/4/16	F 27	2			
	revealed the resident impairment. She wa with bed mobility but	t had moderate cognitive s assessed as independent required limited staff					
	of the MDS assessm a physical restraint for rails were used daily	efers and walking. Section P ent indicated bed rails were or the resident; and, the bed . Section V of the MDS					
	assessment indicated Physical Restraints triggered for the resident and a check mark indicated this would be addressed in her care plan. A review of Resident #11 's care plan (initiated on 6/8/15) revealed the problem of Urinary Incontinence/Pressure Ulcer/Physical						
	s medical record did	ued on 5/4/16. Resident #11 ' not include an assessment bed rails as a physical					
	AM with Nurse #3. Nassigned to care for interview, the nurse rused on both sides oreported the resident	nducted on 5/24/16 at 11:42 Nurse #3 was the hall nurse Resident #11. During the reported ½ side rails were of the resident 's bed. She recould physically get out of when the rails were raised.					
	AM with the MDS nu reported she also as: Interim Director of Nu nurse reviewed Resimbolish MDS assessment. Videtermined whether physical restraint, the "physical restraint" as	nducted on 5/26/16 at 11:05 rse. The MDS nurse sumed responsibilities as the ursing (DON). The MDS dent #11 's section P of the When asked how it was or not the resident had a e MDS nurse reported a ssessment form was not sessment of residents or to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345166 B. WING			05/27/2016		
	ROVIDER OR SUPPLIER	IE		STREET ADDRESS, CITY, STATE, ZIP COD 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 272	physical restraint. The had been trained to cas a physical restrain were used for all resistance were coded as a phynurse then stated, "Beshe reported the Carsummary (Section Verbed rails were only use with positioning. The "This is a restraint-free A follow-up interview at 10:58 with the MD interview, the nurse of the facility utilized 1/2 the side rails were also restraint on the MDS stated, "Technically. Upon inquiry, the MD #11 could get out of the bed rails were raised indicated an assessment to determine whether physical restraint. 6) Resident #2 was a 12/12/12 from a hosp diagnoses which inclimellitus, cardio vascu depressive disorder. The resident's annual assessment (Section bed rails were a physical revealed Residing impaired, had no impaired, had no impaired, had no impaired.	r not the bed rails were a ne MDS nurse stated she code bed rails (when used) at. She reported bed rails dents in the facility and all sical restraint. However, the ut it really isn't a restraint." Are Area Assessment of the MDS) indicated the sed to help Resident #11 at MDS nurse also stated, we facility." Was conducted on 5/27/16 as nurse. During the eiterated that all residents in side rails on both sides and ways coded as a physical assessment. The nurse at these aren't restraints. " So nurse confirmed Resident bed on her own when the however, she also nent had not been completed for not the bed rails were a sidmitted to the facility on	F 272				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED		
		345166	B. WING	 	05/27/2	2016	
	ROVIDER OR SUPPLIER	ме		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CO	(X5) DMPLETION DATE	
F 272	walk during the revies since the previous Nof the MDS assessing Restraints triggered this would be included. The resident 's quale (MDS) assessment indicated bed rails with the resident; and, the limit of the MDS cognitively impaired or lower extremities, mobility and extensified not walk during the falls since the previous Resident #2's active reviewed, including Assessment Summar and summary did not related to the use of restraint.	tance for transfers, did not ew period and had no falls MDS assessment. Section V nent indicated Physical for the resident and indicated	F 27	,			
	indicated the bed ra mobility and to defin a physical restraint. An interview was co AM with Nurse #4. assigned to care for interview, the nurse used on both sides of	vention the plan of care ils were being used for e bed parameters but not as nducted on 5/25/16 at 9:41 Nurse #4 was the hall nurse Resident #2. During the reported ½ side rails were of the resident 's bed. She it could not physically get out					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	(X3) DATE SURVEY COMPLETED	
		345166	B. WING _		05/27/2010	6	
	ROVIDER OR SUPPLIER	ОМЕ		STREET ADDRESS, CITY, STATE, ZIF 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPL O THE APPROPRIATE DAT	ETION	
F 272	Continued From p	age 13	F 2	272			
	AM with the MDS reported she also Interim Director of Nurse indicated the used to aid in the determine whethe physical restraint. had been trained the as a physical restremere used for all rewere coded as a purse then stated, The MDS nurse all restraint-free facility.						
	at 10:58 with the Minterview, the nurse the facility utilized the side rails were restraint on the MI stated, "Technicall Upon inquiry, the #2 could not physis However, she also not been complete the bed rails were 7) Resident #16 w 5/12/15 from a host diagnoses which i osteoarthritis and The resident 's ar assessment (Sect.)	ew was conducted on 5/27/16 MDS nurse. During the se reiterated that all residents in ½ side rails on both sides and always coded as a physical DS assessment. The nurse y, these aren't restraints." MDS nurse confirmed Resident ically get out of bed on her own. indicated an assessment had det to determine whether or not a physical restraint. The same of the facility on spital with cumulative included rheumatoid arthritis, a malignant neoplasm. The property of the sesident in the spital with cumulative included rheumatoid arthritis, a malignant neoplasm.					
		hysical restraint for the resident; were used daily. In addition the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345166	B. WING _			05/27/2016	
	ROVIDER OR SUPPLIER	1E		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 272	MDS revealed Residing impaired, had no impextremities, required and extensive assist walk during the revies since the previous Mof the MDS assessments triggered this would be included. Resident #16's active reviewed, including the Assessment Summar and summary did no related to the use of restraint. Review of the care period Physical restraints whowever as an interview indicated the bed raing mobility and to define a physical restraint. An interview was corea AM with Nurse #4. An assigned to care for interview, the nurse was done both sides or reported the resident of bed on her own. An interview was corea AM with the MDS nureported she also as Interim Director of Ni Nurse indicated that used to aid in the assistant was assigned to aid in the assistant was assigned to aid in the assigned to	ent #2 was cognitively pairment of upper or lower supervision for bed mobility ance for transfers, did not w period and had no falls DS assessment. Section V ent indicated Physical for the resident and indicated	F 2	72			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345166	B. WING			05/27/2016	
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CO 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 272	had been trained to das a physical restrain were used for all resi were coded as a phy nurse then stated, "B The MDS nurse also restraint-free facility." A follow-up interview at 10:58 with the MD interview, the nurse of the facility utilized ½ the side rails were alworestraint on the MDS stated, "Technically, the Upon inquiry, the MD #16 could not physical own. However, she assessment had not determine whether of physical restraint. 8) Resident #3 was of facility on 6/10/13 and diagnoses which included add 3/30/16 indicated cognitively impaired of two staff for transfers indicated bed rails we the resident. There was no document.	the MDS nurse stated she code bed rails (when used) to the she reported bed rails dents in the facility and all sical restraint. However, the ut it really isn't a restraint." stated, "This is a stated, "This is a stated, "This is a stated that all residents in side rails on both sides and ways coded as a physical assessment. The nurse chese aren't restraints." So nurse confirmed Resident ally get out of bed on her also indicated an abeen completed to not the bed rails were a configurably admitted to the dire-admitted 3/10/15 with unded: dementia, insomnia, are MDS (Minimum Data Set) and Resident #3 was severely requiring total assistance of a Section P of the MDS are used as a restraint for seessed for the use of beds	F 27				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING _	(X3) DATE SURVEY COMPLETED			
		345166	B. WING		05/27/2016	
	ROVIDER OR SUPPLIER	ME	1	TREET ADDRESS, CITY, STATE, ZIP CODE 570 NC 8 AND 89 HIGHWAY ANBURY, NC 27016	, 33.22010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 272	Nurse#3 stated that used on both sides on urse revealed their getting out of bed or were in the up position of the use of the us	the half sized bed rails were of Resident #3's bed. The resident was capable of a his own when the bed rails on. on 5/26/16 at 11:05am, the revealed there was no assessment form used to aide sidents. When asked how it resident had a physical durse stated she had been rails (when up) as a physical the nurse then stated, "but it t." She reported the CAA ment Summary) indicated the to help resident with equiry, the MDS Nurse stated ode bed rails (when up) as a d to explain it in the CAA. Ited, "This is a restraint-free derview on 5/27/2016 at Nurse stated that all of the alved side rails on their bed the MDS as a Physical Shurse reported that aren't restraints." The MDS assessment was not nine whether or not the bed the resident as a restraint.	F 272			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345166	B. WING	B. WING		05/27/2016	
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016			
(X4) ID PREFIX TAG			I	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE
F 272	term memory problem decision-making skills on two staff with transindicated bed rails we the resident. There was no docum Resident #14 was assails as a restraint. During an interview of Nurse#5 stated that the used on both sides of nurse revealed the regetting out of bed on were in the up position. During an interview of facility's MDS Nurse in "physical restraint" as in assessment of resi was determined the restraint, the MDS Nutrained to code bed rarestraint. However, the really isn't a restraint. (Care Area Assessment bed rails were used to positioning. Upon income was trained to cophysical restraint and The MDS Nurse state facility." During a second inter 10:58am, the MDS N	dent #14 had short and long ins with severely impaired is, and was totally dependent offers. Section P of the MDS ere used as a restraint for entation available indicating sessed for the use of beds in 5/24/16 at 2:34pm, the half sized bed rails were if Resident #14's bed. The isident was capable of the own when the bed rails in. In 5/26/16 at 11:05am, the revealed there was not seessment form used to aide dents. When asked how it esident had a physical arse stated she had been ails (when up) as a physical the nurse then stated, "but it " She reported the CAA ent Summary) indicated the othelp resident with quiry, the MDS Nurse stated de bed rails (when up) as a lato explain it in the CAA. ed, "This is a restraint-free every wor 5/27/2016 at urse stated that all of the ved side rails on their bed	F	272			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	PLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		345166	B. WING _			05/27/2016	
	ROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, 1570 NC 8 AND 89 HIGH DANBURY, NC 27016	STATE, ZIP CODE		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	"Technically, these a Nurse confirmed an completed to detern rails were used for t	ge 18 S Nurse reported that aren't restraints." The MDS assessment was not nine whether or not the bed the resident as a restraint.	F2	72			
	8/1/11 with diagnose cerebrovascular acc transient paralysis, and transient paralysis and transi	es which included: cident, diabetes mellitus, and joint pain. Inimum Data Set) dated esident #15 had short and croblems and showed ence with decision-making pendent with transfers. OS indicated bed rails were for the resident. mentation available indicating					
	rails as a restraint. During an interview Nurse#3 stated that used on both sides nurse revealed the restraint out of bed or were in the up posit. During an interview facility's MDS Nurse "physical restraint" a in assessment of re was determined the restraint, the MDS Nursined to code bed.	on 5/24/16 at 2:41pm, half sized bed rails were of Resident #15's bed. The resident was capable of his own when the bed rails ion. on 5/26/16 at 11:05am, the revealed there was no assessment form used to aide sidents. When asked how it resident had a physical lurse stated she had been rails (when up) as a physical the nurse then stated, "but it					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345166	B. WING		05/27/2016	
	ROVIDER OR SUPPLIER	DME		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	1 00/27/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 272	(Care Area Assessive bed rails were used positioning. Upon is she was trained to a physical restraint at The MDS Nurse stafacility." During a second int 10:58am, the MDS residents had the hand were coded on Restraint. The MDS "Technically, these Nurse confirmed ar completed to determine the complete the completed to determine the complete the complet	nt." She reported the CAA ment Summary) indicated the it to help resident with inquiry, the MDS Nurse stated code bed rails (when up) as a nd to explain it in the CAA. ated, "This is a restraint-free terview on 5/27/2016 at Nurse stated that all of the alved side rails on their bed the MDS as a Physical S Nurse reported that aren't restraints." The MDS in assessment was not mine whether or not the bed the resident as a restraint. was admitted to the facility on oses which included: e; cerebrovascular accident, ing.	F 27	72		
	2/03/16 indicated R cognitively impaired bed mobility and tra	Minimum Data Set) dated desident #26 was severely dand required supervision for ensfers. Section P of the MDS were used as a restraint for				
		mentation available indicating assessed for the use of beds				
	Nurse#5 stated that	on 5/24/16 at 2:24pm, t half sized bed rails were of Resident #26's bed. The				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345166	B. WING		05/	27/2016
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	•	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	getting out of bed on were in the up position. During an interview of facility's MDS Nurse in "physical restraint" as in assessment of resi was determined the restraint, the MDS Nutrained to code bed rarestraint. However, the really isn't a restraint. (Care Area Assessment of resident is were used to positioning. Upon incomply the same trained to complysical restraint and	sident was capable of his own when the bed rails n. n 5/26/16 at 11:05am, the revealed there was no sessment form used to aide dents. When asked how it resident had a physical rise stated she had been hils (when up) as a physical ne nurse then stated, "but it " She reported the CAA ent Summary) indicated the	F 27	2		
F 278 SS=D	residents had the half and were coded on the Restraint. The MDS "Technically, these are Nurse confirmed an acompleted to determinate were used for the 483.20(g) - (j) ASSES ACCURACY/COORD The assessment must resident's status.	urse stated that all of the yed side rails on their bed as a Physical Nurse reported that en't restraints." The MDS ssessment was not ne whether or not the bed a resident as a restraint. SSMENT VINATION/CERTIFIED t accurately reflect the	F 27	8		7/2/16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345166	B. WING		05/27/2016	
	NAME OF PROVIDER OR SUPPLIER STOKES COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	1 03/21/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 278	Continued From pag		F 27	8		
	A registered nurse n assessment is comp	nust sign and certify that the leted.				
		completes a portion of the gn and certify the accuracy of ssessment.				
	willfully and knowing false statement in a subject to a civil mor \$1,000 for each asso willfully and knowing to certify a material a resident assessment.	I Medicaid, an individual who ply certifies a material and resident assessment is ney penalty of not more than essment; or an individual who ply causes another individual and false statement in a t is subject to a civil money than \$5,000 for each				
	Clinical disagreemer material and false st	nt does not constitute a atement.				
	by: Based on record reviaged facility failed to accuractive diagnosis of dantidepressant in the for 1 of 5 sampled reunnecessary medication. The findings include 1) A review of Residincluded a 2/8/16 Nuprogress note from a	view and staff interviews, the rately assess and include the lepression and use of an e Minimum Data Set (MDS) esidents reviewed for ations (Resident #38). d: ent #38 's medical record urse Practitioner 's (NP) another nursing facility where esided. The NP progress note		Corrective action to be accomplished the resident found to be affected by deficient practice: Resident #38- On May 25, 2016, the assessment was updated by the MI nurse to include the active diagnoside depression and the use of antideprese medication was coded. The care at assessment and care plan were the completed to address the use and monitoring of an antidepressant for depression.	the e DS s of essant rea	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345166	B. WING		05/	27/2016	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
OTOKEO (SOUNTY NURSING UOM	ıe		1	570 NC 8 AND 89 HIGHWAY		
STOKES	COUNTY NURSING HOM	E		D	ANBURY, NC 27016		
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F 278	Continued From page indicated the resident		F	278	Corrective actions to be accomplished	for	
		e/time stamp on this NP			residents having potential to be affecte		
	T	ed the record was faxed to			by the same deficient practice:	u	
	the facility on 3/31/16				Assessments for all residents on		
					psychotropic medications (to include		
	Resident #38 was ad	mitted to the facility on			antidepressants) were reviewed to veri	fy	
	4/1/16 from another r	nursing facility with a			an active diagnosis was documented v	vith	
	cumulative diagnoses	s which included depression.			the care area assessment and care pla	an	
					addressing the use and monitoring of		
		sing Assessment Summary			medications. This review was complet	ed	
		d the following, in part: "			by the MDS nurse and the consultant	_	
	Effexor daily for depre	ession. "			pharmacist on 6-23-2016. All residents		
	Δ review of Resident	#38 's admission MDS			were found to have an active diagnosis psychotropic medications (to include	, 101	
		assessment dated 4/8/16			antidepressants) and the use of		
	,	was assessed to have			antidepressant medication was coded.		
	severely impaired cog				The care area assessment and care pl		
		was totally dependent on			addressed the use and monitoring of a		
	staff for all of his Activ	vities of Daily Living (ADLs).			antidepressant for depression. The		
		assessment (Section I) did			coordination of verification between the	÷	
		ent had an active diagnosis			MDS nurse and consultant pharmacist		
	of depression.				was established on 6-23-2016. The		
					consultant pharmacist completes chart		
		ducted on 5/26/16 at 10:00			reviews and maintains a spreadsheet of)Ť	
	AM with the MDS nur				medications with active diagnoses for		
		sumed responsibilities as the rsing (DON). Upon inquiry			each medication and any changes in medications monthly. This spreadshee	≥ †	
	and review of the Res				will be updated monthly and sent to the		
	assessment, the MDS				MDS nurse.	•	
		rectly omitted from his list of					
	T	ne stated the diagnosis of			Measures to be put in place or systemi	С	
		ave been included as an			changes made to ensure that the defic		
	active diagnosis for R	Resident #38.			practice will not occur:		
					The MDS nurse and consultant		
		admitted to the facility on			pharmacist will complete the assessme		
	4/1/16 from another r				for all active diagnoses and psychotrop		
		s which included depression.			medications (to include antidepressant		
		ssion medication orders			on admission. These will be coded wit		
	dated 4/1/16 included	d 37.5 milligrams Effexor (an			the care area assessment and care pla	411	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345166	B. WING		05/27/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/21/2010	
		_		1570 NC 8 AND 89 HIGHWAY		
STOKES	COUNTY NURSING HOM	E		DANBURY, NC 27016		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 278	Continued From page	e 23	F 27	8		
1 2/0	F 278 Continued From page 23 antidepressant) to be given as one tablet every morning for depression. A review of Resident #38 's admission MDS (Minimum Data Set) assessment dated 4/8/16 revealed the resident was assessed to have severely impaired cognitive skills for daily decision making. He was totally dependent on staff for all of his Activities of Daily Living (ADLs). The resident 's MDS assessment (Section N) of the MDS assessment did not indicate the resident received an antidepressant medication. An interview was conducted on 5/26/16 at 10:00 AM with the MDS nurse. The MDS nurse reported she also assumed responsibilities as the Interim Director of Nursing (DON). The MDS nurse reviewed Resident #38 's MDS assessment. Upon inquiry, she confirmed the use of an antidepressant (Effexor) should have been included among the medications coded on		F 2/	addressing the use and monitoring medications. The consultant pharm will complete chart reviews and ma spreadsheet of medications with addiagnoses for each medication and changes in medications monthly. It spreadsheet will be updated month sent to the MDS nurse for changes residents scheduled for quarterly residents and care pland medications. This coordination was established on 6-23-2016. How we will monitor our performan make sure that solutions are sustain A quality assessment tool has been developed for the CNO or designed review all admission assessments than the next weekly care plan medications.	nacist intain a ctive I any This Ily and and eview. the an of s ce to ned: n e to no later eting to	
				recorded for any psychotropic medications (to include antidepress and coded with the care area assess and care plan addressing the use a monitoring of medications. The CN designee will review that all schedu quarterly reviews and medication or recorded on the spreadsheet update monthly by the consultant pharmacy coded in the care area assessment care plan addressing the use and monitoring of medications. Any discrepancies will be corrected at the time. This will be completed and restricted to the Quality of Life committee and housewide QI committee monthly from the property of the pr	ssment and IO or alled hanges ted sist are t and hat eported d or one	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345166	B. WING		05/27/2016	
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(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 278	Continued From page 24		F 278	achieved and sustained and extended indicated.	d if	
F 279 SS=D	483.20(d), 483.20(k)(COMPREHENSIVE (F 279		7/2/16	
		e results of the assessment d revise the resident's of care.				
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.					
	to be furnished to atta highest practicable ph psychosocial well-bei §483.25; and any ser be required under §40 due to the resident's	=				
	by: Based on record revi facility failed to develor the diagnosis of depre antidepressant medic	ation for 1 of 5 sampled r unnecessary medications		Corrective action to be accomplished the resident found to be affected by the deficient practice: Resident #38- On May 25, 2016, the assessment was updated by the MDS nurse to include the active diagnosis depression and the use of antidepres medication was coded. The care are assessment and care plan were then	ne S of sant a	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345166	B. WING	·····		05/27/2016	
NAME OF PI	ROVIDER OR SUPPLIER	•	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	' DE		
				1570 NC 8 AND 89 HIGHWAY			
STOKES	COUNTY NURSING HOM	IE .		DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 279	Continued From page	e 25	F 27	79			
	Resident #38 was ad	mitted to the facility on		completed to address the us	e and		
	4/1/16 from another r			monitoring of an antidepress			
		s which included depression.		depression.			
		ssion medication orders		·			
		d 37.5 milligrams Effexor (an		Corrective actions to be acco	omplished for		
	antidepressant) to be	given as one tablet every		residents having potential to	be affected		
	morning for depression	on.		by the same deficient practic	e:		
				Assessments for all resident	s on		
		sing Assessment Summary		psychotropic medications (to			
		d the following, in part: "		antidepressants) were review	•		
	Effexor daily for depre	ession. "		MDS nurse on 6-23-16 to ve			
				diagnosis was documented v			
		#38 's admission MDS		area assessment and care p			
		assessment dated 4/8/16		addressing the use and mon	-		
		was assessed to have		antidepressant for depressio			
	severely impaired cog			residents were found to have			
		was totally dependent on vities of Daily Living (ADLs).		diagnosis for psychotropic m			
		assessment (Section I) did		include antidepressants) and antidepressant medication w			
		ent had an active diagnosis		The care area assessment a			
	of depression. Section			addressed the use and moni	-		
	-	ndicate the resident received		antidepressant for depressio	-		
	an antidepressant me						
				Measures to be put in place	or systemic		
	A review of Resident	#38 's care plan (initiated		changes made to ensure tha	•		
		ons made on 4/11/16)		practice will not occur:			
	revealed a problem a	rea related to depression		The MDS nurse and consulta	ant		
	and/or the use of an	antidepressant medication		pharmacist will complete the	assessment		
	was not addressed for	or Resident #38.		for all active diagnoses and	psychotropic		
				medications (to include antid			
		iducted on 5/26/16 at 10:00		on admission. These will be			
	AM with the MDS nur			the care area assessment ar			
	T	sumed responsibilities as the		addressing the use and mon			
		ursing (DON). Upon inquiry		antidepressant for depressio			
	and review of the Res			coordination of verification be			
		S nurse confirmed neither		MDS nurse and consultant p			
	the diagnosis of depr			was established on 6-23-201			
	-	cation was coded correctly		consultant pharmacist will co	•		
	on the MDS. She sta	aleu ine diadnosis ot		reviews and maintains a spre	aadsneet of	1	

AND DLAN OF CORRECTION I DENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345166	B. WING _		_	05/27/2016
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, S 1570 NC 8 AND 89 HIGHV DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)	
F 279	active diagnosis for F assessment should a received an antidepre reported since use of coded correctly, the t medications (which ir did not trigger for the assessment and care address the use and medication for this re MDS nurse indicated Resident #38 to be a for the use of an antid	ave been included as an Resident #38 and the MDS Ilso have indicated he essant. The MDS nurse i the antidepressant was not	F2	medications with a each medication a medications mont will be updated m MDS nurse for chescheduled for qual will update the carcare plan to addression. How we will monit make sure that so A quality assessmedeveloped for the review all admissist than the next wee verify that all active recorded for any predications (to in and coded with the and care plan addression monitoring of medications of the second on the second on the second on the second on the second of the care care plan addression monitoring of medications will time. This will be to the Quality of Leond on the second on the second of the care care plan addression monitoring of medicated and sus indicated.	tor our performance to plutions are sustained: nent tool has been CNO or designee to ion assessments no lackly care plan meeting we diagnoses have been clude antidepressants are area assessment and medication change preadsheet updated on sultant pharmacist a area assessment and sing the use and	os nd otater to en s) ent r ges re d ded
1 004	100.20(11) 1141 LOLINZ	J. W. I. D. I. ILOWOOOOAL				172/10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345166	B. WING		05/27/2016	
	ROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 334 SS=D	that ensure that (i) Before offering the each resident, or the representative receive benefits and potential immunization; (ii) Each resident is offering the contraindicated or the immunized during the (iii) The resident or to representative has the immunization; and (iv) The resident's modocumentation that in following: (A) That the resident representative was put the benefits and pote immunization; and (B) That the resident	relop policies and procedures e influenza immunization, e resident's legal ves education regarding the al side effects of the offered an influenza er 1 through March 31 immunization is medically re resident has already been is time period; the resident's legal the opportunity to refuse redical record includes	F 33	4		
	that ensure that (i) Before offering the immunization, each legal representative the benefits and pote immunization; (ii) Each resident is a	relop policies and procedures e pneumococcal resident, or the resident's receives education regarding ential side effects of the offered a pneumococcal s the immunization is				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345166	B. WING _		05/27/2016	
	ROVIDER OR SUPPLIER	IE		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	E	
(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 SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION	
F 334	already been immuni (iii) The resident or the representative has the immunization; and (iv) The resident's medocumentation that in following: (A) That the resident representative was perfect the benefits and poten pneumococcal immunities. (B) That the resident pneumococcal immunities pneumococcal immunities pneumococcal immunication or recomplete immunication immunication, unless that the resident pneumococcal immunication or recomplete immunication immunication, unless that immunication immunication immunication immunication immunication.	ated or the resident has zed; he resident's legal he opportunity to refuse redical record includes adicated, at a minimum, the at or resident's legal rovided education regarding rotial side effects of inization; and at either received the inization or did not receive amunization due to medical refusal. The based on an assessment remendation, a second inization may be given after 5 rest pneumococcal remedically contraindicated or sident's legal representative	F3	34		
	by: Based on record rev facility failed to admir to a resident who me administration and w consented to the vac reviewed for immuniz The findings included Review of the facility Influenza Vaccine Pre	ho 's Responsible Party had cine for 1 of 5 residents rations (Resident #16). I: Pneumococcal and		Corrective action to be accomplise the resident found to be affected to deficient practice: On 6/22/16, the responsible party for resident #36 was contacted by staff nurse and notified that the pneumococcal vaccine had not be given. After being provided education the CDC Pneumococcal Vaccinformation Statement (VIS) regard	(son) the een ation	

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CENTERS FOR MEDICARE & M		MEDICAID SERVICES	DICAID SERVICES			OMB NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345166	B. WING			05/	27/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
0701/50/	SOUNTY NURSING UOM	-		1	570 NC 8 AND 89 HIGHWAY		
STOKES	COUNTY NURSING HOM	E		D	ANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 334	Continued From page	. 20	-	224			
F 334	Continued From page		F	334			
		residents 65 years and			benefits and potential side effects of the		
		ons included the following:			pneumococcal vaccine, the responsible	е	
		l after age 65; previously			party gave telephone consent for the	L_	
	_	e 65, but less than 5 year			pneumococcal vaccine to be given. T		
		to the vaccine, or thimerisol,			facility standing order for pneumococc		
		y; and patient refusal. Upon " may be given as soon as			vaccine was used to write the physicial order for resident #36. The order was		
		np less than 100.4 degrees)			transmitted to the pharmacy, dose ser		
		Medicate with Tylenol 650			the nursing unit and the pneumococca		
	` ′	ose. The protocol also			vaccine was administered on 6-22-16.		
		on of the vaccine was to be			radome was dammiotored on a 22 re-		
		ledication Administration			Corrective actions to be accomplished	for	
	Record.				residents having potential to be affected		
		mitted Resident #16 was			by the same deficient practice:		
	admitted to the facility	on 5/12/15 from a hospital			Medical records of all residents were		
	with cumulative diagn	oses which included			reviewed for compliance with the facili	ty	
	rheumatoid arthritis, o	osteoarthritis and a			Influenza and Pneumococcal		
	malignant neoplasm.	Her date of birth confirmed			Immunization policy by staff nurse and	l	
	she was over 65 year	s of age.The annual			verified with consultant pharmacist. O	ne	
	Minimum Data Set (M	IDS) assessment dated			resident of the remaining 39 had unkn	own	
		sident #16 was moderately			history of pneumococcal vaccination.	The	
	cognitively impaired.				unit secretary contacted the previous		
	Review of the facility				facility on 6-24-16. Resident vaccinati	on	
	Consent Form for 20				records were received on 6-27-16		
	following: " Influenza				indicating no pneumococcal vaccination	n	
		ed during the month of			had been administered there and not		
	October. (Resident #	- ·			history was documented per review by	′	
		n unless he or she has an			MDS nurse. Hospice nurse was	10	
	,	s, has an allergy to eggs or			contacted by the MDS nurse on 6-27-	16	
	-	coccal vaccine within the			and stated vaccinations may be	0	
	past (5) years. " The				administered to hospice residents. The		
	checked indicating ye	. The signature indicated			MDS nurse will contact the responsible party to discuss vaccination status and		
	that the consent was				review the CDC Pneumococcal Vaccin		
		a telephone on 10/30/15.			Information Statement (VIS) regarding		
		tion Administration Record			benefits and potential side effects of the		
		n October 2016 - 5/26/16			pneumococcal vaccine. The MDS nur		
		o documentation of the			will document the decision of the		
			1				1

Pneumococcal vaccine being given to or refused

responsible party as either consent or

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	\ '	(X3) DATE SURVEY COMPLETED	
		345166	B. WING	·····	05/27/2	016	
	ROVIDER OR SUPPLIER	ИЕ	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COI	(X5) MPLETION DATE	
F 334	5/26/16 revealed no vaccine. Review of the Physic May 2016 revealed is section heading " Voor Lase Dose ": " Fas of 10/14". During interview with Nursing (DON) on 5 indicated that the fact pneumococcal vaccieligible resident was standing order form after which the vaccine DON acknowledged signed standing order vaccine could not be documentation of the vaccine. She stated that residents received	ge 30 cal record for October 2016 - orders for pneumococcal cian 's Order summary for the following under the accine/Immunizations Dates Pneumonia no documentation on the acting Director of /27/16 at 11:32 AM she cility used a standing order for ine, once consent for an is obtained, and there was a that the physician would sign ination could be given. The that for Resident #16 a ter form for pneumococcal te located and there was no te resident receiving the that it was her expectation the Pneumococcal vaccination like Resident #16 and had a	F 33	refusal of vaccine. If consent is the facility standing order for pneumococcal vaccine will be us write the physician order for the The order will transmitted to the pharmacy, dose sent to the nurs and the pneumococcal vaccine vadministered. The MDS nurse is responsible to follow up until the vaccination decision is made and given or documented as declined responsible party. Measures to be put in place or such anges made to ensure that the practice will not occur: Influenza and pneumococcal vaccination yill be assessed for each on admission per policy with vaccination if indicated by the nurse with review by the MDS nuther resident is not aware of vaccinistory and records are not read available, medical records from facilities or clinics will be request unit secretary. Nursing staff will history from the family and/or resparty. After all reasonable attem gather history have been exhaus pharmacy will enter not known a date on the monthly physician of sheet. This documents that the has been asked/investigated and known after investigation completed. The nurse will be upon admission if indicated and per time frame as indicated per code of the process of the nurse will be upon admission. The nurse will be upon admission if indicated and per time frame as indicated per code of the nurse will be upon admission. The nurse will supon admission if indicated and per time frame as indicated per code of the process of the nurse will supon admission. The nurse will supon admission if indicated and per time frame as indicated per code of the nurse will supon admission. The nurse will supon admission if indicated and per time frame as indicated per code of the nurse will supon admission. The nurse will supon admission if indicated and per time frame as indicated per code of the nurse will supon admission. The nurse will supon admission if indicated and per time frame as indicated per code of the nurse will supon admission if indicated and per time frame as indicated per code of the nurse will supon admission if indicated and	sed to resident. ing unit will be so deither do by the sed deficient defici		

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		OATE SURVEY OMPLETED	
		345166	B. WING _			05/27/2016
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(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 CEACH CORRECTIVE ACTOR CEACH CORRECTIVE ACTOR CEACH	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 334	Continued From page	e 31	F3	the decision of the resider party as either consent or vaccine after review of the vaccination information structure consent is obtained, the far order for pneumococcal a vaccine will be used to wrorder for the resident. The transmitted to the pharma the nursing unit and the variation decision is margiven or documented as desident or responsible to follow up un vaccination decision is margiven or documented as desident or responsible particular to the requested for whistory or there is a delay feedback from the responsible particular the weekly care plan agent resolved. How we will monitor our punke sure that solutions as A quality assessment tool developed for the CNO or review all admission assess than the next weekly care verify that vaccination histodetermined and vaccination determined and vaccination histodetermined and vaccination histodetermined and vaccination history or the plan agenda until resolved discrepancies will be correctime. This will be completed to the Quality of Life committed.	refusal of e current atement. If acility standing ind/or influenza ite the physician e order will cy, dose sent to accine will be nurse is intil the ade and either leclined by the arty. If records vaccination in receiving sible party, the ry will be kept on inda until erformance to are sustained: has been designee to ssments no later plan meeting to cory has been ons provided if to be requested here is a delay in the inding vaccination weekly care did Any ected at that teed and reported	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345166	B. WING_			05/	27/2016
	ROVIDER OR SUPPLIER	E	·	15	TREET ADDRESS, CITY, STATE, ZIP CODE 570 NC 8 AND 89 HIGHWAY ANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 334	Continued From page	e 32	F	334	Housewide QI Committee monthly for or year to ensure compliance has been achieved and sustained and extended indicated.		
F 431 SS=D	483.60(b), (d), (e) DR LABEL/STORE DRUG		F4	131	indicated.		7/2/16
	a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliatio records are in order a controlled drugs is ma reconciled. Drugs and biologicals labeled in accordance	officient detail to enable an en; and determines that drug and that an account of all aintained and periodically a used in the facility must be with currently accepted					
	professional principle appropriate accessor instructions, and the applicable.	y and cautionary					
	facility must store all locked compartments	tate and Federal laws, the drugs and biologicals in under proper temperature only authorized personnel to eys.					
	permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when t package drug distribu	ide separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to the facility uses single unit ation systems in which the imal and a missing dose can					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345166	B. WING		05/27/2016	
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/2//2010	
STOKES (COUNTY NURSING HOM	_	,	1570 NC 8 AND 89 HIGHWAY		
SIUNES	COUNTY NURSING HOW	E		DANBURY, NC 27016		
(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 COMPLETION	
F 431	Continued From page	⊇ 33	F 431			
	This REQUIREMENT	is not met as evidenced				
	Based on observation interviews, the facility as specified by the modication carts (201 carts); and, failed to be shortened expiration	ns, record review and staff refailed to store medications anufacturer in 2 of 2 -211 and 212-221 med abel medications with a date in 2 of 2 medication 12-221 medication carts).		Corrective action to be accomplished the resident found to be affected by th deficient practice: The unlabeled Levabuterol for Reside #10 was removed by the pharmacist a adequate stock provided as replacement on 5-25-16.	e nt ind	
	revealed a box of 0.6 (ml) levalbuterol solution medication used to the pulmonary disease and drawer for Resident # medication cart. The medication in an open Manufacturer labeling indicated once the foil	ade on 5/25/16 at 10:17 AM 3 milligrams (mg)/3 milliliters tion for oral inhalation (a eat chronic obstructive nd asthma) was stored in the #10 on the 201-211 box contained two vials of ned, undated foil pouch. g on the levalbuterol pouch il pouch was opened, the		The loose Restasis vials were placed back in the manufacturer box by the pharmacist on 5-25-16 for Resident #* The pharmacist located the dispensed date for the latanoprost ophthalmic solution and labeled the medication for the expiration date from time of dispensing on 5-25-16. The pharmacist located the dispensed date for the Advair for resident #3 and labeled the medication for the expiration of the expiration for the expiration for the expiration of the expiration for the expir	r I	
	s Orders revealed the order for 0.63 mg/3 m used as one vial via r shortness of breath a An interview was con AM with Nurse #1. N 201-211 Hall medicat medication labeling, t	#10 's May 2016 Physician 'ere was a current medication all levalbuterol solution to be nebulizer four times daily for and wheezing. ducted on 5/25/16 at 10:45 turse #1 was assigned to the ion cart. After reviewing the		from time of dispensing on 5-25-16. The pharmacist located the dispensed date for the Advair for resident #19 an labeled the medication for the expiration date from time of dispensing on 5-25- The pharmacist placed a statement in prescription software to automatically label med with day exp date on 1-16. Stickers for documentation of this information are placed on medication packaging prior to dispensing by the	d on 16. the print 5-25	

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	345166		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING _		05	5/27/2016	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE .		
STOKES COUNTY NURSING HOME			1570 NC 8 AND 89 HIGHWAY			
STORES COUNTY NORSING HOME			DANBURY, NC 27016			
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST IN TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
when the foil pouch was opereported she did not know we been opened. An interview was conducted PM with the facility 's Consu During the interview, the phalevalbuterol vials had been medication cart. She indicates should have been dated as sopened so the shortened eximedication could be determined. An interview was conducted Director of Nursing (DON) on AM. Upon inquiry, the DON expect the medications to be when stored on the medication indicated she would expect a stored in accordance with the recommendations. 2) An observation made on the revealed 5 vials of 0.05% Refermulsion (a medication used were stored loose in the draw on the 201-211 medication of manufacturer's box for the stored in another drawer on The manufacturer labeling of included the following statement the thermoformed tray until the thermoformed tray until the thermoformed tray until the stored as one drop to each dry eyes.	on 5/25/16 at 2:30 ultant Pharmacist. armacist reported the emoved from the ted the foil pouch to when it was piration date of the ined. with the Interim in 5/26/16 at 10:08 indicated she would elabeled and dated fons carts. She also all medications to be elemanufacturer 's 5/25/16 at 10:17 AM estasis ophthalmic did to treat dry eyes) wer for Resident #10 eart. The Restasis vials was the medication cart. In the Restasis box ment, "Store vials in use." May 2016 Physician 's a current medication thhalmic emulsion to	F 4	pharmacy technician or pharmackages will be labeled with leave med in manufacturer by the pharmacy technician of when applicable (i.e. Restasis boxes). Staff education by the consult pharmacist has begun for all and dispensing RPhs regardidispensing, labeling and storachanges. This education will completed by July 15, 2016. Corrective actions to be accoresidents having potential to by the same deficient practice. The pharmacist checked all infor the remaining residents and were properly labeled on 5-29. The pharmacist placed a state prescription software to autor label med with day expunded and with day expunded and with are placed on medication are placed on medication are placed on the outer medication by the pharmacy pharmacy technician or pharmacy been placed on the outer medication by the pharmacy pharmacy staff will label the semedication per pharmacy direction of the manufacture and fill in the appropriate expunded.	a statement is packaging or pharmacist is unit dose it ant nursing staffing the age process be implished for be affected e: medications and verified all 5-16. The ment in the matically printically		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345166	B. WING			5/27/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	0/2//2010	
				1570 NC 8 AND 89 HIGHWAY			
STOKES (COUNTY NURSING HOM	E		DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIES ID CY MUST BE PRECEDED BY FULL PREFIX R LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 431	Continued From page	e 35	F 43	31			
	AM with Nurse #1. N 201-211 Hall medicat medication labeling, t know why the Restas of the manufacturer ' An interview was con PM with the facility 's During the interview, Restasis vials, "shoor removed " from the ruse. An interview was con	ducted on 5/25/16 at 2:30 s Consultant Pharmacist. the pharmacist reported the		leave med in manufacturer by the pharmacy technician of when applicable (i.e. Restasis boxes). Statements will automatically the pharmacy screens when entered. Pharmacy staff will comply with statements which print on computer generated administration records (MARS) the nursing staff. Staff education by the consul pharmacist has begun for all and dispensing RPhs regardi	or pharmacist s unit dose appear on the script is read and h will also medication S) used by tant nursing staff		
	AM. Upon inquiry, the expected all medicati accordance with the recommendations.	e DON indicated she ons to be stored in		dispensing, labeling and stora changes. This education will completed by July 15, 2016.	age process be		
	revealed an opened lead to ophthalmic solution (a glaucoma) was stored #19 on the 212-221 representation was not dated as to very solution.	ade on 5/25/16 at 10:22 AM pottle of 0.005% latanoprost a medication used to treat d in the drawer for Resident medication cart. The bottle when it had been placed in emperature and/or opened.	prost practice will not occur teat The pharmacist place ident prescription software to ottle label med with d d in -16. Stickers for docu		ement in the matically print date on 5-25 ion of this edication		
	solution indicated into should be stored und opened, the solution temperature for 6 we A review of Resident s Orders revealed the order for 0.005% lata	g for latanoprost ophthalmic act bottles of the solution er refrigeration. Once may be stored at room eks. #19 's May 2016 Physician 'ere was a current medication noprost ophthalmic solution op into both eyes daily for		pharmacy technician or pharmacy technician or pharmacy technician or pharmacy and the expiration dates for specific in have been placed on the outer medication by the pharmacy pharmacist. The nursing staff pharmacy staff will label the significant medication per pharmacy direction the manufacture and fill in the appropriate exp	macist. coumenting nedications er label of the technician or f or specific ection at the urer package		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		UULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345166	B. WING _			05/	27/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
0701/70		_		15	570 NC 8 AND 89 HIGHWAY		
STOKES	COUNTY NURSING HOM	IE .		D	ANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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) COMPLETION DATE
F 431	Continued From page glaucoma.		F 4	131	Packages will be labeled with stateme		
	AM with Nurse #2. N 212-221 Hall medical medication labeling of	ducted on 5/25/16 at 10:40 Iurse #2 was assigned to the tion cart. After reviewing the on the latanoprost solution, knew there was a shortened			leave med in manufacturer s packag by the pharmacy technician or pharma when applicable (i.e. Restasis unit do boxes).	acist	
	expiration date that n this medication. How when the eye drops h			Statements will automatically appear on the pharmacy screens when the script is entered. Pharmacy staff will read and comply with statements which will also			
	PM with the facility 's During the interview,	ducted on 5/25/16 at 2:30 s Consultant Pharmacist. the pharmacist reported the should have been dated as to			print on computer generated medicating administration records (MARS) used the nursing staff.		
	expiration date of the determined.				Scripts are entered into pharmacy software prior to dispensing therefore information is available to pharmacy software checking medications has been adjusted about this policy.		
	Director of Nursing (I	educted with the Interim DON) on 5/26/16 at 10:08 DON indicated she would			been educated about this policy on 5-27-16.		
	expect the medicatio when stored on the nalso indicated she we to be stored in according recommendations	ns to be labeled and dated nedications carts. The DON ould expect all medications dance with the manufacturer			Staff education by the consultant pharmacist has begun for all nursing s and dispensing RPhs regarding the dispensing, labeling and storage procedunges. This education will be completed by July 15, 2016.		
	revealed a 250/50 minhaler (a medication chronic obstructive p asthma) was stored i on the 201-211 medication as to when it had been pouch.	illigram (mg) Advair Diskus used in the management of ulmonary disease and n the drawer for Resident #3 cation cart. The inhaler had The inhaler was not dated en removed from the foil			How we will monitor our performance make sure that solutions are sustained A weekly medication cart check will be completed to review that all dispensed doses are labeled prior to dispensing labeling /packaging is maintained on the nursing unit by the MDS nurse or nurse unit by the	d: d: d: d: di and he se ll be hs,	
	Manufacturer labeling	g for the Advair Diskus			reviews will be completed monthly. T	he	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRU				TE SURVEY MPLETED	
		345166	B. WING			5/27/2016	
NAME OF PROVIDER OR SUPPLIER STOKES COUNTY NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		33/27/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 431	discarded 1 month pouch, or when the (whichever comes A review of Reside s Orders revealed order for 250/50 m used as one inhala obstructive pulmor breath. An interview was can AM with Nurse #1. 201-211 Hall medication labeling Diskus inhaler showhen the foil pouch reported she did not been opened. An interview was can PM with the facility During the interview Advair Diskus inhalato when it had bee expiration date of the determined. An interview was can provide the medication of Nursing AM. Upon inquiry, expect the medication when stored on the also indicated she to be stored in accordination.	after removal from the foil adosing indicator read "0" first). Int #3's May 2016 Physician' there was a current medication g Advair Diskus inhaler to be ation every 12 hours for chronic hary disease and shortness of conducted on 5/25/16 at 10:45 Nurse #1 was assigned to the cation cart. After reviewing the graph that the following the following the following the following that the following the follow	F	results will be recorded the Quality of Life Co Housewide QI Commyear to ensure compliachieved and sustain indicated.	mmittee and the nittee monthly for one liance has been		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345166	B. WING		05/27/2016	
NAME OF PROVIDER OR SUPPLIER STOKES COUNTY NURSING HOME			1	TREET ADDRESS, CITY, STATE, ZIP CODE 570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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 COMPLETION	
F 431	inhaler (a medication chronic obstructive pasthma) was stored #19 on the 212-221 had 24 doses remaindated as to when it infoil pouch. Manufacturer labeling inhaler indicated the discarded 1 month a pouch, or when the control (whichever comes fill a review of Resident's Orders revealed the order for 250/50 mg used as one inhalatif obstructive pulmona. An interview was contained and interview was contained as a shortened as a shortened was a shortened to be observed to be observed to the discarding the interview was contained. An interview was contained to when it had been expiration date of the determined.	nilligrams (mg) Advair Diskus in used in the management of pulmonary disease and in the drawer for Resident medication cart. The inhaler ming. The inhaler was not mad been removed from the ag for the Advair Diskus Diskus device should be after removal from the foil dosing indicator read "0" rst). at #19's May 2016 Physician' were was a current medication Advair Diskus inhaler to be on every 12 hours for chronic	F 431			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345166	B. WING _			05/27/2016	
NAME OF PROVIDER OR SUPPLIER STOKES COUNTY NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP (1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 431	AM. Upon inquiry, the expect the medication when stored on the malso indicated she wo	DON) on 5/26/16 at 10:08 e DON indicated she would ns to be labeled and dated nedications carts. The DON ould expect all medications lance with the manufacturer	F	431			