### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 345278 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET NORTHERN SURRY SNF MOUNT AIRY, NC 27030 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 483.10(a)(1) DIGNITY AND RESPECT OF F 241 F 241 2/28/17 INDIVIDUALITY SS=E (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff F241 interview, the facility failed to maintain residents' Plan of correction dignity by standing over 4 of 4 sample residents (Resident #11, Resident #29, Resident #6, and For resident #11 and all residents having Resident #21) while assisting them to eat a meal. potential to be affected. All staff have been educated by DON on The findings included: assisting with feeding of residents and proper procedures related to positioning 1) Resident #11 was admitted to the facility on and being at eye level beginning 2-10-17 5/3/13 from the community. Her cumulative with completion 2-28-17. No negative outcome was identified by the diagnoses included dementia. alleged deficient practice. A review of Resident #11 's guarterly Minimum Education to alter practice to ensure that Data Set (MDS) assessment dated 11/1/16 revealed the resident had severely impaired the problem does not reoccur included if cognitive skills for daily decision making. The unable to sit at eye level to feed the resident required total assistance from staff for all patient and standing staff to raise bed to of her Activities of Daily Living (ADLs), with the eve level. Education also included to not exception of requiring limited assistance with sit on a bed while feeding a resident. All personal hygiene. new hires will be educated on the proper feeding technique to include feeding the On 2/7/17 at 12:56 PM, Resident #11 was resident at eye level. observed as she was fed her noon meal by Nursing Assistant (NA) #1. Resident #11 was Corrective action will be monitored to lying in bed with the head of the bed elevated. ensure the alleged deficient practice will NA #1 was observed standing over the resident not re occur. next to the bed as she assisted her with the meal. The DON/Designee will complete a daily The nursing assistant was observed to be audit of two feedings (1 at breakfast and I at lunch) daily for 7 days for 2 weeks. standing above eye level for Resident #11. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed

(X6) DATE 03/03/2017

PRINTED: 04/17/2017

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.

		MEDICAID SERVICES	0.000		OMB NO. 0938-0
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345278	B. WING		02/10/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE
NORTHE	RN SURRY SNF			830 ROCKFORD STREET MOUNT AIRY, NC 27030	
(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 ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLET HE APPROPRIATE DATE
F 241	Continued From page	e 1	F 24	1	
	she entered Residem Resident #11 with he observed standing ov bed as she assisted H was observed to be s while assisting Resid An interview was con at 2:34 PM. During th Resident #11 would t occasions, but typica staff to help finish the NA #1 stated she trie the bed and face the this worked depender resident. The NA rep raise the resident 's not standing over her facility doesn ' t want	ducted with NA #1 on 2/9/17 he interview, the NA reported		<ul> <li>Then 2x a day for 3 days a breakfast and 1 at lunch) for for a total amount of 46 obs</li> <li>The DON/Designee will mo audits for compliance. Monitoring of compliance w at the March 2017 and Aprimeeting.</li> <li>F241</li> <li>Plan of correction For resident #29 and all respotential to be affected.</li> <li>All staff have been educate assisting with feeding of resproper procedures related t and being at eye level begin with completion 2-28-17.</li> </ul>	or three weeks servations. nitor the daily rill be reported I 2017 QA sidents having d by DON on sidents and o positioning nning 2-10-17
	AM with the facility 's in regards to the obse standing over resider meals. During the int the beds in the facility standard nursing faci beds were higher tha bed and could not be staff to sit at eye leve The DON stated she and would rather hav can better reach the	ducted on 2/10/17 at 10:20 s Director of Nursing (DON) ervations made of staff hts while assisting them with terview, the DON reported y were hospital beds (versus lity beds). She stated the n a standard nursing facility lowered enough to allow el while feeding a resident. has recognized this issue te the staff standing so they resident, be eye level to talk and encourage them to		No negative outcome was in alleged deficient practice. Education to alter practice to the problem does not reocco unable to sit at eye level to patient and standing staff to eye level. Education also in sit on a bed while feeding a new hires will be educated feeding technique to include resident at eye level. Corrective action will be more ensure the alleged deficient not re occur: The DON/Designee will cor audit to ensure of proper	to ensure that bur included if feed the praise bed to included to not resident. All on the proper e feeding the ponitored to t practice will

Facility ID: 953376

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345278 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET NORTHERN SURRY SNF MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 241 Continued From page 2 F 241 2) Resident #29 was admitted to the facility on feeing/positioning 4/7/14 from the community. His cumulative The DON/Designee will complete a daily diagnoses included dementia. audit of two feedings (1 at breakfast and I at lunch) daily for 7 days for 2 weeks. A review of Resident #29 's guarterly Minimum Then 2x a day for 3 days a week (1 at Data Set (MDS) assessment dated 11/22/16 breakfast and 1 at lunch) for three weeks revealed the resident had severely impaired for a total amount of 46 observations. cognitive skills for daily decision making. The DON/Designee will monitor the daily Resident #29 required total assistance from staff audits for compliance. for all of his Activities of Daily Living (ADLs), with Monitoring of compliance will be reported at the March 2017 and April 2017 QA the exception of requiring limited assistance with personal hygiene. meeting. On 2/7/17 at 12:55 PM, Resident #29 was observed as he was fed his noon meal by F241 Nursing Assistant (NA) #4. Resident #29 was lying in bed with the head of the bed elevated. Plan of correction For resident #6 and all residents having NA #4 was observed standing over the resident next to the bed as she assisted him with the potential to be affected. meal. The NA was observed to be standing All staff have been educated by DON on above eye level for Resident #29. assisting with feeding of residents and proper procedures related to positioning On 2/9/17 at 8:18 AM, NA #3 was observed and being at eye level beginning 2-10-17 standing over Resident #29 's bed as she with completion 2-28-17. assisted the resident with his breakfast meal. No negative outcome was identified by the The NA was observed to be standing above the alleged deficient practice. resident 's eye level while assisting him. Upon inquiry, the NA reported Resident #29 had a good Education to alter practice to ensure that appetite and was eating well. the problem does not reoccur included if unable to sit at eye level to feed the An interview was conducted with NA #4 on patient and standing staff to raise bed to 2/10/17 at 9:11 AM. During the interview, the NA eye level. Education also included to not was asked what the facility policy was in regards sit on a bed while feeding a resident. All to standing while assisting a resident with a meal. new hires will be educated on the proper The NA reported the facility preferred staff to sit feeding technique to include feeding the when feeding a resident. However, NA #4 resident at eye level. reported she had back and shoulder issues so if she sat by the side of the bed, she would Corrective action will be monitored to experience pain from having to twist around. ensure the alleged deficient practice will

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

		MEDICAID SERVICES			OMB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED	
		345278	B. WING		02/10/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHEF	RN SURRY SNF			830 ROCKFORD STREET MOUNT AIRY, NC 27030		
(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 APPR DEFICIENCY)	JLD BE COMPLETIC	
F 241	Continued From page	e 3	F 24	1		
	A telephone interview on 2/10/17 at 10:05 A stated she "has a hal residents. NA #3 rep what the facility polic encouraged sitting w eat. An interview was con AM with the facility 's in regards to the obse standing over resider meals. During the im the beds in the facility standard nursing faci beds were higher that bed and could not be staff to sit at eye leve The DON stated she and would rather hav can better reach the resident, and able to eat. 3) Resident #6 was a 8/22/11, with re-entry The resident was refe Hospice on 2/8/17. A review of Resident Data Set (MDS) asset	was conducted with NA #3 AM. Upon inquiry, the NA bit" of standing when feeding ported she was unsure as to y was, but thought they hile assisting a resident to aducted on 2/10/17 at 10:20 s Director of Nursing (DON) ervations made of staff hts while assisting them with terview, the DON reported y were hospital beds (versus lity beds). She stated the in a standard nursing facility e lowered enough to allow el while feeding a resident. has recognized this issue re the staff standing so they resident, be eye level to talk and encourage them to admitted to the facility on from the hospital on 1/4/17. erred and admitted to #6 ' s admission Minimum		<ul> <li>not re occur: The DON/Designee will complete a audit to ensure of proper feeing/positioning. The DON/Desig complete a daily audit of two feedin at breakfast and I at lunch) daily fo for 2 weeks. Then 2x a day for 3 d week (1 at breakfast and 1 at lunch three weeks for a total amount of 4 observation</li> <li>Monitoring of compliance will be reat the March 2017 and April 2017 (meeting).</li> <li>F241</li> <li>Plan of correction</li> <li>For resident #21 and all residents I potential to be affected.</li> <li>All staff have been educated by the on assisting with feeding of resider proper procedures related to positi and being at eye level beginning 2 with completion 2-28-17. No negative outcome was identifie alleged deficient practice.</li> <li>Education to alter practice to ensurt the problem does not reoccur incluunable to sit at eye level to feed the patient and standing staff to raise beam of the provent of the problem does not reacted to positi and being at eye level to feed the patient and standing staff to raise beam of the provent of the pro</li></ul>	nee will ngs (1 r 7 days lays a n) for -6 ported QA having e DON nts and oning -10-17 d by the re that ded if e	
	dependent on staff for Living (ADLs), with the extensive assistance	g. The resident was totally or all of her Activities of Daily ne exception of requiring with dressing and personal oted to be independent with		eye level. Education also included sit on a bed while feeding a resider new hires will be educated on the feeding technique to include feedin resident at eye level.	nt. All proper	

Facility ID: 953376

If continuation sheet Page 4 of 52

STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	PLETED		
		345278	B. WING		02	2/10/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
NORTHER	RN SURRY SNF		830 ROCKFORD STREET MOUNT AIRY, NC 27030					
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
F 241	Continued From page	e 4	F 24	1				
	A review of Resident dated 1/9/17 included assist the resident with On 2/7/17 at 12:58 Pl observed as she was Nursing Assistant (N/ in bed with the head was observed standing the bed as she assist NA was observed to b for Resident #6. An attempt was made 2/8/17 at 10:20 AM. sleepy and did not ver posed. On 2/9/17 at 8:20 AM she entered Resident the NA was observed next to the bed as shi her breakfast meal. If standing above eye la resident to eat. An interview was con with Nurse #2. Nurse care for Resident #6. confirmed the resider was not interviewable health and mental sta	<ul> <li>#6 's Nutrition Care Plan d an intervention for staff to th feeding as needed.</li> <li>M, Resident #6 was fed her noon meal by A) #2. Resident #6 was lying of the bed elevated. NA #2 ng over the resident next to ed her with the meal. The be standing above eye level</li> <li>e to interview Resident #6 on The resident appeared very trobally respond to questions</li> <li>I, NA #2 was observed as t #6 's room. At 8:26 AM, I standing over the resident e assisted Resident #6 with NA #2 was observed to be evel while assisting the</li> <li>ducted on 2/9/17 at 9:24 AM e #2 had been assigned to Upon inquiry, Nurse #2 nt was verbal at times but e due to her recent decline in atus.</li> </ul>		Corrective action will be monitore ensure the alleged deficient pract not re occur. The DON/Designee will complete audit of two feedings (1 at breakf at lunch) daily for 7 days for 2 we Then 2x a day for 3 days a week breakfast and 1 at lunch) for three for a total amount of 46 observati Monitoring of compliance will be a at the March 2017 and April 2017 meeting.	e a daily ast and I eeks. (1 at e weeks ons.			
	2/10/17 at 10:00 AM. assisted residents with standing, the NA state	ducted with NA #2 on When asked if she usually th their meals while sitting or ed, "It all depends on the sit on the edge of the bed to						

Facility ID: 953376

If continuation sheet Page 5 of 52

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/17/2017 M APPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345278	B. WING			02	/10/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHER	RN SURRY SNF				830 ROCKFORD STREET MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 241	feed the resident." The policy indicated the step level when assist However, the NA state place to sit when she mealtime. An interview was comain and the facility is a sin regards to the obsets standing over resident meals. During the interview the beds in the facility standard nursing facility standard nursing facility beds were higher that bed and could not be staff to sit at eye level. The DON stated she and would rather have can better reach the resident, and able to the eat. 4) Resident #21 was 8/16/11 from the comain diagnoses included A A review of Resident and the resident cognitive skills for dai Resident #21 required for all of her Activities On 2/10/17 at 8:40 AI was observed standing the bed as she made the resident with her bed as	he NA reported the facility 's taff member should be at ting residents to eat. ed there was not always a assisted a resident at ducted on 2/10/17 at 10:20 b Director of Nursing (DON) ervations made of staff the while assisting them with terview, the DON reported y were hospital beds (versus lity beds). She stated the n a standard nursing facility lowered enough to allow I while feeding a resident. has recognized this issue the staff standing so they resident, be eye level to talk and encourage them to admitted to the facility on munity. Her cumulative lzheimer 's disease. #21 's quarterly Minimum issment dated 11/2/16 had severely impaired	F	241			

If continuation sheet Page 6 of 52

		MEDICAID SERVICES				O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		· · ·	E SURVEY IPLETED	
		345278	B. WING		02	2/10/2017	
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP COD	E		
NORTHEF	RN SURRY SNF		830 ROCKFORD STREET MOUNT AIRY, NC 27030				
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 241	Continued From page	e 6	F 241				
		#21 appeared to be resistant the time of the observation.					
	2/10/17 at 9:11 AM. was asked what the f to standing while ass The NA reported the when feeding a resid- reported she had bac she sat by the side of	k and shoulder issues so if					
F 070	AM with the facility 's in regards to the obse standing over resider meals. During the int the beds in the facility standard nursing faci beds were higher tha bed and could not be staff to sit at eye leve The DON stated she and would rather hav can better reach the p resident, and able to eat.	ducted on 2/10/17 at 10:20 a Director of Nursing (DON) ervations made of staff hts while assisting them with terview, the DON reported y were hospital beds (versus lity beds). She stated the n a standard nursing facility lowered enough to allow I while feeding a resident. has recognized this issue e the staff standing so they resident, be eye level to talk and encourage them to	E 070			2/40/47	
F 278 SS=E		SMENT DINATION/CERTIFIED ssments. The assessment	F 278			2/10/17	
	must accurately refle	ct the resident's status.					
	<ul> <li>(h) Coordination</li> <li>A registered nurse m</li> <li>each assessment wit</li> <li>participation of health</li> </ul>						

Facility ID: 953376

If continuation sheet Page 7 of 52

# DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING \_\_\_\_ 345278 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET NORTHERN SURRY SNF MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 278 Continued From page 7 F 278 (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the F278 facility failed to code active diagnoses on the comprehensive assessment tool, the Minimum Corrective action for Resident #7 and all Data Set (MDS), for 2 of 5 sampled residents residents having potential to be affected. reviewed for unnecessary medications (Resident #7 and Resident #27); and, failed to accurately MDS-RN received education that included code the MDS to reflect the medications that the diagnosis have to be entered administered during the 7-day look back period each time that a MDS is created on for 2 of 5 sampled residents reviewed for 2-10-17 from Point Click Care vendor unnecessary medications (Resident #7 and representative on software capability Resident #27). related to Section I-diagnosis. DON

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

Facility ID: 953376

If continuation sheet Page 8 of 52

					OMB NO.	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		345278	B. WING		02/10	0/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	IP CODE	
NORTHEF	RN SURRY SNF					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 278	Continued From page	e 8	F 27	78		
	The findings included			educated MDS-RN on co Section I-diagnosis each entered due to Point Clic	n time MDS ck Care system	
	5/7/14 with re-entry fr Her cumulative diagn Obstructive Pulmona	admitted to the facility on rom the hospital on 9/21/16. oses included Chronic ry Disease (COPD), chronic		not automatically popula diagnosis on 2-10-17. T deficient practice does n MDS-RN now understan	o ensure that this not reoccur nds that the	
	Gastro-Esophageal R depression, atrial fibr	mentia, hypertension, Reflux Disease (GERD), illation (an irregular Ind Chronic Kidney Disease		diagnosis will have to be time an MDS is started. 100% audit of MDS entr		
	Stage 3. A review of Resident	#7 ' s quarterly Minimum		by DON with each MDS 50% of MDS entered to weeks by DON. Ongoin 30% check of all MDS co	entry x2 weeks. be audited x2 g there will be a	
	revealed Section I (A identify the presence	ctive Diagnoses) did not of any active diagnoses ovided in that section. Also,		by DON. Monitoring of compliance		
	the option of checking diagnoses within the selected. No addition	g "None of the above active last 7 days" was not nal active diagnoses were		to the monthly QA comm starting in March 2017 a until September 2017.	nittee meting	
	Section I.	provided at the bottom of		F278		
	with the MDS Nurse.	ducted on 2/9/17 at 3:33 PM Upon inquiry, the MDS dent #7 ' s active diagnoses		Corrective action for Res residents having potentia		
	(from the electronic records. The nurse re	•		MDS-RN received educa that the diagnosis have t each time that a MDS is	to be entered	
	stated she should hav diagnoses in the blan	ks at the bottom of Section		2-10-17 from Point Click representative on softwa related to Section I-diag	are capability nosis. DON	
	<ol> <li>The additional diag included: GERD, uns respiratory failure: de</li> </ol>			educated MDS-RN on co Section I-diagnosis each entered due to Point Clic	n time MDS	
		fied iron-deficiency anemia.		not automatically popula diagnosis on 2-10-17. T	ting Section I o ensure that this	
	An interview was con	ducted on 2/10/17 at 7:40		deficient practice does n	not reoccur	

Facility ID: 953376

If continuation sheet Page 9 of 52

### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345278 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET NORTHERN SURRY SNF MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 278 Continued From page 9 F 278 AM with the facility 's Director of Nursing (DON). MDS-RN now understands that the During the interview, the DON stated she would diagnosis will have to be entered each expect the MDS assessments to be coded time an MDS is started. properly. 100% audit of MDS entry to be completed 1b) Resident #27 was admitted to the facility on by DON with each MDS entry x2 weeks. 7/9/15. Her cumulative diagnoses included 50% of MDS entered to be audited x2 Generalized Anxiety Disorder (GAD), weeks by DON. Ongoing there will be a anxiety/agitation, insomnia, hypertension, 30% check of all MDS completed monthly Gastro-Esophageal Reflux Disease (GERD), gout by DON. and hypothyroidism. Monitoring of compliance will be reported A review of Resident #27 's quarterly Minimum to the monthly QA committee meeting Data Set (MDS) dated 1/18/17 revealed Section I starting March 2017 and will continue (Active Diagnoses) did not identify the presence September 2017. of any active diagnoses from the check list provided in that section. Also, the option of F278 checking "None of the above active diagnoses within the last 7 days" was not selected. No Corrective action for Resident #7 and all residents having potential to be affected. additional active diagnoses were reported in the space provided at the bottom of Section I. MDS-RN received education of An interview was conducted on 2/10/17 at 7:40 completion of Section N coding and drug AM with the facility 's Director of Nursing (DON). types on 2-10-17 by DON. DON educated During the interview, the DON stated she would on RAI process regarding medication expect the MDS assessments to be coded classes properly. 100% audit of MDS input to be completed An interview was conducted on 2/10/17 at 11:42 by DON on each MDS entered x 2 weeks. AM with the MDS Nurse. During the interview, Then 30% of MDS entered to be audited x the nurse reported she had contacted the support 2 weeks by Director of Nursing. Ongoing service for the facility 's MDS software earlier there will be a 30% check of all MDS that morning. The MDS nurse reported she was completed monthly by DON. told Section I of the MDS was auto-populated so it would show up on the computer screen as if it Monitoring of compliance will be reported had been completed. The nurse stated she to the monthly QA committee meeting believed this was the reason why she had missed beginning March 2017 thru September filling out Section I of the MDS assessment. 2017.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 953376

						NO. 0938-039
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · · ·	ATE SURVEY OMPLETED
		345278	B. WING			02/10/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
NORTHE	RN SURRY SNF					
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 278	Continued From page	e 10	F 27	8		
	5/7/14 with re-entry fr	admitted to the facility on rom the hospital on 9/21/16. oses included depression		F278		
a A	and atrial fibrillation (a	an irregular heartbeat).		Corrective action for Resider residents having potential to		
	Data Set (MDS) asse revealed Section N (N resident received bot medications on 7 out back period. Section	#7 ' s quarterly Minimum essment dated 12/14/16 Medications) reported the h antianxiety and hypnotic of the 7 days during the look N did not indicate the antidepressant, an		MDS-RN received education completion of Section N codi types on 2-10-17 by DON. D on RAI process regarding me classes.	ng and drug ON educated	
	resident received an antidepressant, an anticoagulant, nor an antibiotic medication during the 7-day look back period. A review of the resident 's December 2016 Medication Administration Record (MAR) revealed the resident received the following			100% audit of MDS input to the by DON on each MDS entered Then 30% of MDS entered to 2 weeks by Director of Nursin there will be a 30% check of completed monthly by DON.	ed x 2 weeks. be audited x ng. Ongoing	
	medications on a dail (mg) sertraline (an ar tablet by mouth once anticoagulant) given a daily; 0.5 mg lorazepa medication) given as hours as needed; 50 tablet by mouth every mirtazapine given as once daily at bedtime	y basis: 100 milligrams ntidepressant) given as one daily; 5 mg Eliquis (an as one tablet by mouth twice		Monitoring of compliance will to the monthly QA committee beginning March 2017 thru S 2017.	emeeting	
	with the MDS Nurse. Nurse reviewed Resid paper charts. After h confirmed that while s coded accurately for other medications we	ducted on 2/9/17 at 3:33 PM Upon inquiry, the MDS dent #7 ' s electronic and er review, the nurse Section N of the MDS was the antianxiety medication, ere not. The MDS nurse did receive an anticoagulant				

If continuation sheet Page 11 of 52

	-	D HUMAN SERVICES				FORM	: 04/17/2017 1APPROVED
STATEMENT O	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE COMP	
		345278	B. WING		_	02/ <sup>.</sup>	10/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
NORTHER	N SURRY SNF		-	30 ROCKFORD STREET	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	during the look back p uncertain as to why sl received a hypnotic m may have counted tra instead of an antidepr to code Macrobid in S antibiotic given 7 out of specifically addressed An interview was come AM with the facility 's During the interview, f expect the MDS asse properly. 2b) Resident #27 was 7/9/15. Her cumulativ Generalized Anxiety D anxiety/agitation, and A review of Resident si Data Set (MDS) dated N (Medications) repor antipsychotic, antianx on 7 out of the 7 days period. Section N did received an antidepre back period. A review of the resident Medication Administra revealed the resident medications on a daily citalopram (an antidep tablet by mouth once antipsychotic) given a	essants (sertraline, rapine) on 7 out of 7 days beriod. The nurse was he had reported the resident hedication but believed she uzodone as a hypnotic ressant medication. Failure Section N of the MDS as an of 7 days was not d during the interview. ducted on 2/10/17 at 7:40 Director of Nursing (DON). the DON stated she would ssments to be coded a admitted to the facility on ve diagnoses included Disorder (GAD), insomnia. #27 ' s quarterly Minimum d 1/18/17 revealed Section ted the resident received an iety and hypnotic medication a during the look back not indicate the resident essant during the 7-day look	F 278				

Facility ID: 953376

If continuation sheet Page 12 of 52

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SU	0938-039
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLE	
		345278	B. WING		02/10	)/2017
NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
NORTHEF	RN SURRY SNF			ROCKFORD STREET UNT AIRY, NC 27030		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 278	Continued From page	e 12	F 278			
	one tablet by mouth t	wice daily; and 15 mg				
	temazepam (a hypnotic medication) given as one capsule by mouth once daily at bedtime. An interview was conducted on 2/10/17 at 7:40					
		s Director of Nursing (DON).				
	-	the DON stated she would				
	properly.	essments to be coded				
	An interview was con	ducted on 2/10/17 at 11:42				
		rse. Upon inquiry, the MDS				
		dent #27 ' s electronic and ig the January 2017 MAR.				
		nurse confirmed Resident				
		ntidepressant (citalopram) on				
		g the look back period. The				
		use of the antidepressant ported in Section N of the				
F 279		1) DEVELOP	F 279		3	/6/17
SS=E						
	483.20					
		ist maintain all resident ted within the previous 15				
		nt's active record and use the				
		ments to develop, review				
		nt's comprehensive care				
	plan.					
	483.21					
	(b) Comprehensive C	Care Plans				
		develop and implement a				
		on-centered care plan for				
	and resident consis	tent with the resident rights				

Facility ID: 953376

If continuation sheet Page 13 of 52

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	04/17/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE S COMPLI	
		345278	B. WING		-	02/1	0/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
NORTHE	RN SURRY SNF			330 ROCKFORD STREET MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 279	set forth at §483.10(c includes measurable to meet a resident's m and psychosocial nee comprehensive asses care plan must descri (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483. provided due to the re under §483.10, includ treatment under §483 (iii) Any specialized so rehabilitative services provide as a result of recommendations. If a findings of the PASAF rationale in the reside (iv)In consultation with resident's representat (A) The resident's goa desired outcomes. (B) The resident's pre- future discharge. Fac whether the resident's community was asses	<ul> <li>and §483.10(c)(3), that objectives and timeframes nedical, nursing, and mental eds that are identified in the sement. The comprehensive be the following -</li> <li>are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse .10(c)(6).</li> <li>arvices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record.</li> <li>and the resident and the tive (s)-</li> <li>als for admission and</li> <li>aference and potential for ilities must document is desire to return to the sed and any referrals to se and/or other appropriate</li> </ul>	F 279				

If continuation sheet Page 14 of 52

						NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · ·	TE SURVEY
		345278	B. WING			)2/10/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
NORTHEF	RN SURRY SNF			830 ROCKFORD STREET MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IMARY STATEMENT OF DEFICIENCIES ID EFICIENCY MUST BE PRECEDED BY FULL PREFIX 'ORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLET CROSS-REFERENCED TO THE APPROPRIATE DATE		
		,		DEFICIENCY		
F 279	Continued From page	e 14	F 2	79		
	(C) Discharge plans i	n the comprehensive care				
		in accordance with the				
		h in paragraph (c) of this				
	section.					
		is not met as evidenced				
	by:					
		ons, record reviews, and staff		F279		
	interviews, the facility	•				
		plan for 1 of 3 sampled		Corrective action for Resider		
		(30) reviewed for range of		29 and residents affected by	alleged	
	and #30) reviewed fo	3 sampled residents (#29 r activities.		deficient practice.		
	Findings included:			The care plan for resident #2	9 was	
				reviewed and updated to refl residents needs to include a	ect the	
	1. Resident #30 was	admitted to the facility on		preferences. To ensure that the	•	
	7/23/14 with diagnose	es which included:		practice dose not reoccur the	MDS-RN	
	cerebrovascular accie			and Activity Director were ed	ucated by the	
	weakness, rheumatoi	id arthritis, and		DOn on the requirement that	a facility	
	osteoarthritis.			must develop a comprehens	ve care plan	
				for each resident based on the	ne care needs	
		MDS (minimum data set)		identified in the comprehensi	ve	
		ated Resident #30 was		assessment which includes A	Activities on	
		and had limited range of		2/13/17.		
	motion of her bilatera	I lower extremities.				
	There was no plan of			100 % Audit of current reside		
	-	d interventions to address		was completed by DON on 3		
		nt related to Resident #30's		determine that care plans ref		
	range of motion need	ls.		residents needs based on the		
				comprehensive assessment.	-	
		n on 2/7/17 at 12:30pm,		incomplete care plans identif	ied were	
		ting up in her bed, feeding		updated by MDS-RN.		
	herself lunch. The res					
	answered questions v	with confused responses.		50% audit of care plans to be		
		- 0/0/47 -+ 4:00		2 weeks by DON/Designee.		
		n 2/9/17 at 4:39pm, the		there will be a 30% monthly a		
	INDS Nurse revealed	Resident #30 had not been		completed by DON/Designee		

Facility ID: 953376

If continuation sheet Page 15 of 52

### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345278 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET NORTHERN SURRY SNF MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 279 Continued From page 15 F 279 ambulatory since admission. She acknowledged the resident was not, but should have been care Implementation of Activity Attendance Log planned for ADLs (activities of daily living) which completed and implemented on 3-1-17 to would have included the resident's limited range record attendance of activities for all of motion of her lower extremities. residents. Monitoring of compliance will be reported to QA committee monthly beginning 2. Resident #29 was admitted to the facility on 4/7/14 with diagnoses which included: March 2017 thru September 2017. Alzheimer's disease, dementia, aphasia, and adult failure to thrive. The quarterly MDS (minimum data set) dated Corrective action for Resident #30 and 11/22/16 indicated Resident #29 was severely residents affected by alleged deficient cognitively impaired. practice. There was no plan of care with measurable goals To ensure that the deficient does not and interventions to address care and treatment reoccur the MDS-RN and Activity Director were educated by DON on the related to Resident #29's participation in activities. requirement that a facility must develop a comprehensive care plan for each During an observation on 2/7/17 at 12:55pm, resident based on the care needs Resident #29 was lying in bed assisted with his identified in the comprehensive meal by a nursing assistant. The resident was not assessment which includes activities and verbal, unable to answer questions. range of motion on 2-13-17 by DON. During an interview on 2/10/17 at 2:45pm, the The care plan for resident #30 was Activity Director indicated Resident #29 was reviewed and updated to reflect the always in bed, sleeping most of time and did not residents needs to include range of respond to verbal stimuli. She revealed the motion and activity preferences on 3/6/17. activity she provided with the resident was one on one talking to the resident once every five days. 100 % Audit of current resident care plans She also revealed that she did not maintain an was completed by DON on 3-1-17 to Activity Attendance Log for residents. determine that care plans reflect the residents needs based on the most recent During an interview on 2/10/17 at 5:02pm, the comprehensive assessment. Any MDS Nurse confirmed there was no Activity Care incomplete care plans identified were Plan available for Resident #29, but there should updated by MDS-RN. have been.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 953376

If continuation sheet Page 16 of 52

	S FOR MEDICARE &					O. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY PLETED
		345278	B. WING		02	2/10/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
NORTHEF	N SURRY SNF			830 ROCKFORD STREET MOUNT AIRY, NC 27030		
(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 ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 279	Continued From page	e 16	F 279	9		
	7/23/14 with diagnose cerebrovascular accie weakness, rheumato	Solution       Solution <td< td=""><td>. Ongoing / audit ee.</td><td></td></td<>		. Ongoing / audit ee.		
	dated 11/23/16 indica cognitively impaired a	MDS (minimum data set) ated Resident #30 was and had activity preferences outside and religious		Monitoring of compliance w to QA committee at next mo beginning March 2017 thru 2017.	onthly meeting	
	and interventions to a	care with measurable goals address care and treatment 30's activity preferences.				
	Resident #30 was sitt herself lunch. The res	n on 2/7/17 at 12:30pm, ting up in her bed, feeding sident was alert but with confused responses.				
	During an interview on 2/9/17 at 10:50am, Resident #30's daughter revealed she volunteered at the facility working with the Activity Director on Monday through Saturday, but still visited the resident on Sundays, after church. She revealed the resident used to get out of bed for group Bingo but currently refused. She also revealed that she visited with the resident every day to talk about current events.					
	Nurse acknowledged	n 2/9/17at 3:00p, the MDS Resident #30 should have r activities, stating "I missed				
F 280		3),483.21(b)(2) RIGHT TO	F 280			3/9/17

If continuation sheet Page 17 of 52

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/17/2017 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE	
		345278	B. WING				02/	10/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	ODE		
NORTHEF	N SURRY SNF				830 ROCKFORD STREET MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD B		(X5) COMPLETION DATE
F 280 SS=D	PARTICIPATE PLANN 483.10 (c)(2) The right to part and implementation of plan of care, including (i) The right to particip including the right to i be included in the plan request meetings and revisions to the perso (ii) The right to particin expected goals and of amount, frequency, and other factors related to plan of care. (iv) The right to receive included in the plan of (v) The right to see the right to sign after sign of care. (c)(3) The facility shall right to participate in the shall support the reside planning process must	NING CARE-REVISE CP ticipate in the development f his or her person-centered g but not limited to: Date in the planning process, dentify individuals or roles to nning process, the right to I the right to request n-centered plan of care. Pate in establishing the utcomes of care, the type, nd duration of care, and any o the effectiveness of the re the services and/or items f care. e care plan, including the ificant changes to the plan I inform the resident of the his or her treatment and dent in this right. The st sion of the resident and/or re. ment of the resident's	F	280		·* ))		

Facility ID: 953376

If continuation sheet Page 18 of 52

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/17/2017 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		345278	B. WING			02/	10/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHER	RN SURRY SNF				30 ROCKFORD STREET IOUNT AIRY, NC 27030		
(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)	ЗE	(X5) COMPLETION DATE
F 280	cultural preferences ir 483.21	n developing goals of care.	F	280			
	<ul><li>(b) Comprehensive C</li><li>(2) A comprehensive</li></ul>						
		days after completion of					
	(ii) Prepared by an int includes but is not lim	terdisciplinary team, that ited to					
	(A) The attending phy	vsician.					
	(B) A registered nurse resident.	e with responsibility for the					
	(C) A nurse aide with resident.	responsibility for the					
	(D) A member of food	and nutrition services staff.					
	the resident and the r An explanation must I medical record if the p	ticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined e development of the					
		staff or professionals in ined by the resident's needs e resident.					
		vised by the interdisciplinary ssment, including both the juarterly review					

Facility ID: 953376

If continuation sheet Page 19 of 52

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345278 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET NORTHERN SURRY SNF MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 280 Continued From page 19 F 280 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff F280 interviews, the facility failed to revise the Care Plan of 1 of 3 residents reviewed for significant Corrective action for residents affected by weight loss. (Resident #16). alleged deficient practice. The care plan for Resident #16 was reviewed and Findings included: updated to reflect the residents needs to include a dietary care plan. Resident #16 was admitted to the facility on MDS-RN, Dietician, and Pharmacist were 5/27/10 with diagnoses which included: educated by DON on 3-1-17 and Social congestive heart failure, anemia, hypothyroidism, Worker on 3-2-17 of requirement to edema, dysuria, and hypothyroidism. complete a comprehensive assessment for each resident including dietary. Review of the most recent MDS (minimum data set) dated 11/16/16 indicated Resident#16 was 100 % Audit of current resident care plans severely, cognitively impaired; was independent was completed by DON on 3-1-17 to with eating; had weight gain; and received a determine that care plans reflect the therapeutic diet. residents needs based on the most recent comprehensive assessment. Any The Weights for this resident in six months were: incomplete care plans identified were Weight on 1/2/17 was 99 lbs. (pounds); updated by MDS-RN. Weight 30 days ago (12/05/2016): 108 lbs. (which is 9 lbs. less than on the first date or a 9.1% loss) 50% audit of care plans to be completed x Weight 90 days ago (10/06/2016): 99 lbs. (which 2 weeks by DON/Designee. is 0 lbs. more than on the first date or a 0.0% gain) Ongoing there will be a 30% monthly audit Weight 180 days ago (08/04/2016): 105 lbs. completed by DON/Designee. (which is 6 lbs. less than on the first date or a 6.1% loss) Entry of dietary care plans into Point Click Care will be completed by 3-9-17. The review of Resident #16's Care Plan was not Monitoring of compliance will be reported updated to include the resident's fluctuations in weight status. the next guarterly QA meeting. During an observation and interview on 2/10/17 at 9:00am, Resident #16 was completing her

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 953376

If continuation sheet Page 20 of 52

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 1 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE	
		345278	B. WING			02/	10/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
NORTHER	N SURRY SNF		-	30 ROCKFORD STREET IOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 280 F 329 SS=D	NA#2 indicated the refeed herself some of I (NA#2) would assist t remaining meal. During an interview of RD (Registered Dietit received a no added s finely chopped meats resident's desirable w 52.5 inches was 73-8 resident has had weig (three months prior), t off between 107 lbs. t then begin to fluctuate During an interview of confirmed the Nutritio updated and acknowl to include Resident # 483.45(d)(e)(1)-(2) DF FROM UNNECESSA 483.45(d) Unnecessa Each resident's drug funnecessary drugs. drug when used (1) In excessive dose therapy); or (2) For excessive durate (3) Without adequate	NA#2 (nursing assistant). sident was able and would her meal and stop; then she he resident with the in 2/10/17 at 10:16am, the ian) revealed Resident #16 salt, lactose free diet with . The RD stated that the reight range for her height of 9 lbs. She revealed the ght variations in the past then her weight would level o 109 lbs. for two months e again for a few months. In 2/10/17 at 5:35pm, the RD n Care Plan was not edged it should have been 16's weight fluctuations. RUG REGIMEN IS FREE RY DRUGS ry Drugs-General. regimen must be free from An unnecessary drug is any (including duplicate drug ation; or	F 280				3/6/17

Event ID: 6XL911

Facility ID: 953376

If continuation sheet Page 21 of 52

	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345278	B. WING		02/10/2017
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	•
NORTHER	N SURRY SNF			330 ROCKFORD STREET	
				MOUNT AIRY, NC 27030	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIO
F 329	Continued From page	e 21	F 329		
	F 329 Continued From page 21 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or				
	, , ,	s of the reasons stated in ough (5) of this section.			
	483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that				
	drugs are not given the medication is necess	ave not used psychotropic hese drugs unless the ary to treat a specific ed and documented in the			
	gradual dose reduction interventions, unless an effort to discontinu	clinically contraindicated, in			
	Based on record rev pharmacist interviews and attempt a Gradu	s, the facility failed to identify al Dose Reduction (GDR) or		F329 Plan of Correction	
	(lorazepam), and a h medication ordered f	ued need for an opram), an antianxiety ypnotic (temazepam) or 1 of 5 sampled residents ssary drugs (Resident #27).		Dose reductions for Lorazepam (PRI Temazepam, and Citalopram were initiated for resident #27 on 02/10/17 Scheduled Lorazepam dose was red	
	The findings included			on 3/6/17.	
		a.		Audit was completed on 2-10-17 by	
		lmitted to the facility on ve diagnoses included Disorder (GAD).		pharmacist for those residents having potential to be affected by the alleged deficient practice.	

Facility ID: 953376

# PRINTED: 04/17/2017 FORM APPROVED

If continuation sheet Page 22 of 52

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIE	PLE CONSTRUCTION		<u>10. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		3	· · · ·	MPLETED
		345278	B. WING		a	2/10/2017
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP COD		
NORTHER				830 ROCKFORD STREET		
NORTHER	RN SURRY SNF			MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETIO DATE
F 329	Continued From page	e 22	F 32	29		
	anxiety/agitation, and					
				To protect residents in similar	situations	
	A review of Resident			and ensure problem does not		
		evealed her medications		regimens for each resident ar		
	included the following			each month by the pharmacis		
		pram given as one tablet by		Pharmacist will recommend g		
	-	ng lorazepam given as one		reduction attempts at this time	-	
		daily; 1 mg lorazepam given eded for anxiety; and 15		the discontinuation of unnece medications. A monitoring to		
	-	as one capsule by mouth		employed by the pharmacist t		
	every night at bedtime			tracking gradual dose reduction		
	5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	-		sedative/hypnotics, anti-anxie		
	A review of Resident	#27 ' s quarterly Minimum		and antipsychotic medications		
	Data Set (MDS) date	d 1/18/17 revealed the		Pharmacist will attend weekly	care-plan	
		ely impaired cognitive skills		meetings and discuss resider	ťs	
	-	king. She was independent		medication therapy with spec		
	- ·	limited assistance from staff		focused on gradual dose redu		
		nd personal hygiene, and		above mentioned medications		
		sistance for dressing and		Discussion to include, but not	,	
	resident did not exhib	f the MDS indicated the		medication name and current date of last gradual dose redu		
	rejection of care.	any benaviors not		attempt, and (3) whether the		
				reduction trial is successful or		
	A review of Resident	#27 ' s February 2017		care plan meeting it is found t		
		evealed her medications		gradual dose reduction attem		
		orders: 20 mg citalopram		the above mentioned medicat	ions has not	
		y mouth once daily; 1 mg		occurred in the past quarter, t		
		one tablet by mouth twice		pharmacist will initiate a reque		
		n given every two hours as		dose reduction to the attendin	- · ·	
		nd 15 mg temazepam given		that day. The MDS Coordina		
		outh every night at bedtime.		determine which residents are for the weekly care plan meet		
	Further review of Res	sident #27 ' s medical record		100% of residents care plan		
		o documentation of GDRs		once every 90 days. Pharma		
	having been address			attend monthly Quality Assura		
	-	epam currently prescribed.		Meetings where gradual dose attempts for the previous mor	reduction	
		ducted on 2/10/17 at 2:09		reported. Dose reduction		
	PM with the facility 's	s consultant pharmacist.		recommendations will be made	le to	

Facility ID: 953376

# DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345278 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET NORTHERN SURRY SNF MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 329 Continued From page 23 F 329 Upon inquiry, the pharmacist reported he would provider and tracked on enclosed form. expect to address GDRs for lorazepam and Documentation of dose reductions will be temazepam every 3-4 months, and an placed in the resident's medical record. antidepressant such as citalopram "less often" than that. Monitoring of compliance will be reported monthly beginning in March 2017 thru A follow-up interview was conducted on 2/10/17 February 2018 to QA Committee. at 4:30 PM with the consultant pharmacist. At that time, the pharmacist reported he reviewed DON will review residents drug regimens his records and found GDRs had not been for unnecessary drugs and documented attempts at gradual dose reduction on attempted at any time for the citalopram, lorazepam, nor temazepam prescribed for monthly basis. Resident #27. The pharmacist reported he had already telephoned the resident 's PA and received new medication orders for the GDRs. When asked if the need for addressing Resident #27 's GDRs for the citalopram, lorazepam, and temazepam had been missed, the pharmacist stated, "yes." A copy of the Observation and Recommendation Note written by the consultant pharmacist on 2/10/17 for Resident #27 included the following actions taken and new medication orders received from the resident 's PA: --"Leave scheduled lorazepam as is; --Decrease PRN (as needed) lorazepam to 0.5 mg po (by mouth); --Decrease temazepam to 7.5 mg po q HS (every night at bedtime) PRN sleep; --Decrease citalopram to 10 mg po daily." An interview was conducted on 2/10/17 at 4:45 PM with the facility 's Director of Nursing (DON). During the interview, failure to address GDRs for the citalopram, lorazepam, and temazepam for Resident #27 's was discussed. Upon inquiry, the DON stated she would expect GDRs to be monitored and addressed. She indicated she

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

If continuation sheet Page 24 of 52

	OF DEFICIENCIES	MEDICAID SERVICES					D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, <i>'</i>				PLETED
		345278	B. WING			02/	/10/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHER	N SURRY SNF				30 ROCKFORD STREET OUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page	e 24	É F	329			
		ssion to be held with the					
	physician and docum	nented attempts for the GDR					
	-	y, a reason documented as					
F 332	to why the attempt co	F MEDICATION ERROR	E .	332			3/3/17
SS=D	RATES OF 5% OR M			552			5/5/17
	(f) Medication Errors. that its-	The facility must ensure					
	greater;	rates are not 5 percent or Γ is not met as evidenced					
	Based on observation	ons, record review, and staff / failed to have a medication			F332		
	error rate less than 5	% as evidenced by 2			Corrective Action for resident #1 and all		
	medication errors out				residents having potential to be affected		
		tion error rate of 8%, for 2 of t #1 and Resident #15)			by alleged deficient practice. Resident a had no negative outcomes. MD/family	#1	
	observed during med				notified of medication error.		
	The findings included	i:			The nurse involved with medication error		
	1) On 2/8/17 at 4⋅05	PM, Nurse #1 was observed			was educated by DON prior to survey ex on five rights of medication administration		
	-	is for administration to			Remaining nurses received education o		
	Resident #1. The me	edications pulled for			five rights of medication administration t		
		ed a Flovent HFA inhaler with			DON by 3-3-17.		
		g) per actuation (puff). The as she administered two			Medication pass audit completed by DO	N	
		to the resident. Flovent HFA			with 50% of nurses completed by 2-24-1		
	is a corticosteroid inh				To monitor performance the DON will		
	management of asthi	ma.			audit a 25 count medication pass 2x ead		
	A review of Resident	#1 's physician medication			month for 6 months to ensure a less tha 5% medication pass error rate. All new	111	
		rrent order for Flovent HFA			nurses will be educated on the 5 rights of	of	
		e given as 2 puffs in the			medication administration during		
	morning and 1 puff in	the evening (scheduled for			orientation.		

Facility ID: 953376

If continuation sheet Page 25 of 52

# PRINTED: 04/17/2017 FORM APPROVED

A. BUILDING A. BUILDING 02/10/2017          345278       B. WING 02/10/2017         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         830 ROCKFORD STREET       MOUNT AIRY, NC 27030         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES	STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         STREET           NORTHERN SURRY SNF         STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES         SUMMARY STATEMENT OF DEFICIENCIES         MOUNT AIRY, NC 27030           CMUD         SUMMARY STATEMENT OF DEFICIENCIES         PROVIDERS PLAN OF CORRECTION         EACH CONCENT STATEMENT OF DEFICIENCIES         COMMENT           TAG         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDERS PLAN OF CORRECTION         COMMENT           TAG         SUMMARY STATEMENT OF DEFICIENCIES         PROVIDERS PLAN OF CORRECTION         EACH CONCENT STATEMENT OF DEFICIENCIES         COMMENT           TAG         SUMMARY STATEMENT OF DEFICIENCIES         PROVIDERS PLAN OF CORRECTION         COMMENT           TAG         SUMMARY STATEMENT OF DEFICIENCIES         PROVIDERS PLAN OF CORRECTION         COMMENT           TAG         SUMMARY STATEMENT OF DEFICIENCIES         F 332         Continued From page 25         STREET ADDRESS, CITY, STATE, ZIP CODE         COMMENT           TAG         An interview was conducted with Nurse #1 on 2/8/17 at 4:30 PM. Nurse #1 transchowledged the directions written on each indicated nony 1 puff of the Flovent HFA should have been given to Resident #1 in the evening. The nurse stated she did not notice these         F332         Corrective Action for resident #15 and all resident bar in the evening. The nurse stated she did not notice these         F15 h	ND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
NORTHERN SURRY SNF         BB ROCKFORD STREET MOUNT AIRY, NC 27030           (M) ID TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO DEFICIENCY TAG         PROVIDERS FLAN OF CORRECTION (EACH DEFICIENCY)         COUNT AIRY, NC 2008 (EACH DEFICIENCY)         COUNT AIRY, NC 2008 (EACH DEFICIENCY)           F 332         Continued From page 25 5:00 PM).         F 332         F 332         F 332           S ADDROK (MARS) AND THE PREVENTION INFORMATION)         F 332         F 332         Monitoring of compliance will be reported to the next monthly OA committee meeting beginning in March 2017 thru September 2017.         F 332           Monitoring of Compliance will be reported to the parmacy labeling, NURS#1 acknowledged the directions written on each indicated only 1 puff of the Flovent HFA 110 mcg inhaler used. Upon review of the MAR and pharmacy labeling, NURS#1 acknowledged the administration meeting beginning in March 2017 thru September 2017.         F 332           Corrective Action for resident #15 and all residents having potential to be affected by alleged deficient practice. Resident #15 had no negative outcomes. MD/family notified or medication error. More rights of medication administration. Remaining nurses received education on five rights of medication administration. Resident #15. The medications pulled for administration included one - 500 microgram (mcg) Vitamin B12 tablet. The nurse was observed as she admininistreation to			345278	B. WING		02/10/2017		
NORTHERN SURRY SNF         MOUNT AIRY, NC 27030           (x) (0) PRETIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PREFIX PREFIX TAG         PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         (200 PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)           F 332         Continued From page 25 5:00 PM).         F 332         F 332           An interview was conducted with Nurse #1 on 2/8/17 at 4:30 PM. Nurse #1 reviewed Resident #1 's February 2017 Medication Administration Record (MAR) and the administration instructions written on the pharmacy labeling, Nurse #1 acknowledged the directions written on each indicated only 1 puff of the Flovent HFA 110 mcg inhaler used. Upon review of the MAR and pharmacy labeling, Nurse #1 acknowledged the directions written on each indicated she add not notice these directions and acknowledged she administred two puffs of Flovent HFA to the resident during the medication pass observation, instead of one puff as prescribed.         F 332         Corrective Action for resident #15 and all residents having potentiate to be affected by alleged deficient practice. Resident #15 had no negative outcomes. MD/family notified of medication error. The nurse involved with medication error was educated by DON prior to survey exit on five rights of medication administration. Remaining nurses creived education on five and as to any a medication for administration to Resident #15. The medication pass addit completed by DON with 50% of nurses completed by 2-24-17. To monitor performance the DON will audit a 25 count medication pass 2x each monitor performance the DON will audit a 25 count medication gaston administration medication administration fulled	NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
Prefix TAG         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)         COMPLETE DEFICIENCY           F 332         Continued From page 25 5:00 PM).         F 332         F 332         Monitoring of compliance will be reported to the next monthly QA committe meeting beginning in March 2017 thru September 2017.         Monitoring of compliance will be reported to the next monthly QA committe meeting beginning in March 2017 thru September 2017.           F 332         F 332           Continued From page 25 5:00 PM).         F 332           An interview was conducted with Nurse #1 reviewed Resident #1 's February 2017 Medication Administration Record (MAR) and the administration instructions written on the pharmacy labeling, Nurse #1 acknowledged the directions written on each indicated only 1 puff of the Flovent HFA should have been given to Resident #1 in the evening. The nurse stated she did not notice these directions and acknowledged she administered two puffs of Flovent HFA the resident during the medication pass observation, instead of one puff as prescribed.         The nurse involved with medication error was educated by DON prior to survey exit on five rights of medication administration. Remaining nurses received education on five rights of medication administration. Remaining nurses received education on five rights of medication administration. Remaining nurses completed by 2-24-17. To monitor performance the DON will audit a 25 count medication pass 2x each month fox 6 months to ensure a less than 5% exitation included one -500 microgram (mcg) Vitamin B12 tablet. The nuruse was observed as she administreted the medication to	NORTHEF	RN SURRY SNF						
<ul> <li>5:00 PM).</li> <li>An interview was conducted with Nurse #1 on 2/8/17 at 4:30 PM. Nurse #1 reviewed Resident #1's February 2017 Medication Administration Record (MAR) and the administration instructions written on the pharmacy labeling of the Flovent HFA 110 mcg inhaler used. Upon review of the MAR and pharmacy labeling, Nurse #1 acknowledged the directions written on each indicated only 1 puff of the Flovent HFA should have been given to Resident #1 in the evening. The nurse stated she did not notice these directions and acknowledged she administered two puffs of Flovent HFA to the resident during the medication pass observation, instead of one puff as prescribed.</li> <li>An interview was conducted with the facility 's Director of Nursing (DON) on 2/10/17 at 4:45 PM. Upon inquiry, the DON indicated her expectation was to have a medication error rate of less than 5%.</li> <li>2) On 2/9/17 at 8:19 AM, Nurse #3 was observed preparing medications pulled for administration included one - 500 microgram (mcg) Vitamin B12 tablet. The nurse was observed as he administered the medication to</li> </ul>	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION		
<ul> <li>An interview was conducted with Nurse #1 on 2/8/17 at 4:30 PM. Nurse #1 reviewed Resident #1's February 2017 Medication Administration Record (MAR) and the administration instructions written on the pharmacy labeling of the Flovent HFA 110 mcg inhaler used. Upon review of the MAR and pharmacy labeling, Nurse #1 acknowledged the directions written on each indicated only 1 puff of the Flovent HFA should have been given to Resident #1 in the evening. The nurse stated she did not notice these directions and acknowledged she administered two puffs of Flovent HFA to the resident during the medication pass observation, instead of one puff as prescribed.</li> <li>An interview was conducted with the facility 's Director of Nursing (DON) on 2/10/17 at 4:45 PM. Upon inquiry, the DON indicated her expectation was to have a medication error rate of less than 5%.</li> <li>2) On 2/9/17 at 8:19 AM, Nurse #3 was observed preparing medications for administration to Resident #15. The medications pulled for administration included one - 500 microgram (mcg) Vitamin B12 tablet. The nurse was observed as she administered the medication to</li> </ul>	F 332		e 25	F 332	2			
A review of Resident #15 's physician medication orders and the resident 's February 2017 Medication Administration Record revealed there was a current order for two - 500 mcg Vitamin B12 tablets to be given daily. An interview was conducted with Nurse #3 on		An interview was con 2/8/17 at 4:30 PM. N #1 's February 2017 Record (MAR) and the written on the pharma HFA 110 mcg inhaler MAR and pharmacy I acknowledged the dir indicated only 1 puff have been given to R The nurse stated she directions and acknow two puffs of Flovent H the medication pass of puff as prescribed. An interview was con Director of Nursing (E Upon inquiry, the DO was to have a medica 5%. 2) On 2/9/17 at 8:19 preparing medication Resident #15. The m administration included (mcg) Vitamin B12 ta observed as she adm the resident. A review of Resident orders and the reside Medication Administra was a current order for B12 tablets to be given	lurse #1 reviewed Resident Medication Administration he administration instructions acy labeling of the Flovent used. Upon review of the abeling, Nurse #1 rections written on each of the Flovent HFA should Resident #1 in the evening. did not notice these wledged she administered dFA to the resident during observation, instead of one ducted with the facility ' s DON) on 2/10/17 at 4:45 PM. N indicated her expectation ation error rate of less than AM, Nurse #3 was observed s for administration to hedications pulled for ed one - 500 microgram blet. The nurse was hinistered the medication to #15 ' s physician medication ent ' s February 2017 ation Record revealed there or two - 500 mcg Vitamin en daily.		<ul> <li>to the next monthly QA committee meeting beginning in March 2017 the September 2017.</li> <li>F332</li> <li>Corrective Action for resident #15 arresidents having potential to be affee by alleged deficient practice. Reside #15 had no negative outcomes. MD/family notified of medication error The nurse involved with medication was educated by DON prior to surver on five rights of medication administrate Remaining nurses received educated five rights of medication administrate DON.</li> <li>Medication pass audit completed by with 50% of nurses completed by 2-To monitor performance the DON wir audit a 25 count medication pass 2x month fox 6 months to ensure a less 5% medication pass error rate. All n nurses will be educated 5 rights of medication.</li> <li>Monitoring of compliance will be rep to the next monthly QA committee meeting beginning in March 2017 the second second</li></ul>	nd all cted ent or. error ey exit tration. on on ion by 2DON 24-17. ill c each s than ew		

Facility ID: 953376

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	ECONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · /		COMPLETED
		345278	B. WING		02/10/2017
NAME OF PI	ROVIDER OR SUPPLIER		ç	STREET ADDRESS, CITY, STATE, ZIP CODE	
NORTHEF	RN SURRY SNF			330 ROCKFORD STREET MOUNT AIRY, NC 27030	
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE
F 332	2/10/17 at 12:40 PM. #3 reported she mad medication pass obs Resident #15 one Vit the two tablets order	During the interview, Nurse e a mistake during the ervation when she gave amin B12 tablet instead of	F 332		
F 333 SS=E	Director of Nursing (I Upon inquiry, the DC was to have a medic 5%.	DON) on 2/10/17 at 4:45 PM. N indicated her expectation ation error rate of less than NTS FREE OF	F 333		3/3/17
	483.45(f) Medication The facility must ens				
	by: Based on hospital at and staff, pharmacist (PA) interviews, the f extended release for antihypertensive med (metoprolol succinate of 30 days. This occ (Resident #33) review discharged from the myocardial infarction The findings included	Γ is not met as evidenced Ind facility record reviews, and Physician Assistant acility failed to provide the mulation of an dication as ordered b) to a resident over a period urred for one of one resident wed who had been recently hospital after experiencing a (heart attack). d: Imitted to the facility on		F333 Corrective action for Resident #33 and residents having potential to be affected by alleged deficient practice. Resident #33 had no negative outcomes. MD/family notified of medication error. The nurse involved with transcription of order was educated 2-15-17 on transcribing orders by DON. The remaining nurses received education b 3-3-17 by DON. New nurses will be education on the transcription process ensure accurate transcription during	d f y

Facility ID: 953376

If continuation sheet Page 27 of 52

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345278 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET NORTHERN SURRY SNF MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 333 Continued From page 27 F 333 that the problem does not reoccur the A review of Resident #33 's December 2016 and transcription process has been changed January 2017 Physician Orders (through 1/5/17) to include verification by two nurses. revealed her medications included 25 milligrams (mg) metoprolol tartrate (an immediate release 100% audit of transcription of new admits formulation of an antihypertensive medication) medication orders has been completed given as one tablet by mouth twice daily. since 2-13-17 by DON to ensure accuracy of Medication Administration Record. A review of the resident 's medical record DON will audit 100% of new admit orders revealed that on 1/5/17, Resident #33 complained of dizziness and stated, "I'm fainting." She was within 48 hours of admission to ensure lowered to the floor by a Nursing Assistant. The accuracy of transcription and MAR for 6 resident 's vital signs were taken and included an months initial blood pressure of 221/88 with a follow up Monitoring of compliance will be reported blood pressure of 200/83 (an optimal blood at the next monthly QA committee pressure is typically less than 120/80). The meeting beginning in March 2017 thru resident was transported to the Emergency September 2017. Department and admitted to the hospital with a diagnosis of a myocardial infarction. Resident #33 was readmitted to the facility on 1/11/17. A review of the resident 's hospital Discharge Medication list dated 1/11/17 revealed her new medications included 25 mg metoprolol succinate to be given as one tablet by mouth once daily. The hospital Discharge Medication list also noted her discontinued medications included 25 mg metoprolol tartrate given twice daily. According to Lexi-Comp, a comprehensive on-line drug information resource, metoprolol tartrate is an immediate release formulation of an antihypertensive medication. Therefore, the total daily dosage of metoprolol tartrate should be given in 2 - 3 divided doses each day. However, Lexi-Comp indicates metoprolol succinate is an extended release formulation of the antihypertensive medication. The total daily

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 28 of 52

ND PLAN OF	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		TE SURVEY MPLETED
		345278	B. WING		0	2/10/2017
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COL		
NORTHER	N SURRY SNF			830 ROCKFORD STREET		
				MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETIO DATE
F 333	Continued From pag	je 28	F 33	3		
	dosage of metoprolol succinate is given as one dose daily.					
	and Medication Adm dated 1/11/17 reveal handwritten. Both th MAR indicated Resid "metoprolol 25 mg p once a day at 8:00 A orders did not specif to be provided as me metoprolol succinate were not initialed or transcribed the order Resident #33 ' s Adm (MDS) dated 1/16/17 the resident had mod skills for daily decisid independent with ear assistance from staff room, toileting and p	he physician orders and the dent #33 was to receive, o (by mouth) daily" scheduled M. The 1/11/17 handwritten by whether the metoprolol was etoprolol tartrate or e. The handwritten orders signed to identify who rs. nission Minimum Data Set 7 was reviewed and revealed derately impaired cognitive on making. She was ting, required limited f for transfers, walking in her personal hygiene. The ed as needing extensive				
	2017 Physician Orde Resident #33 was so metoprolol tartrate g 8:00 AM and 5:00 Pl instructions "twice da scheduled dose were and, a handwritten n	ent 's type-written February ers and MAR indicated cheduled to receive 25 mg iven as 1 tablet twice daily at M. However, both the aily" and the 5:00 PM e crossed out on the forms totation which read "daily" he medication. The notation				

If continuation sheet Page 29 of 52

PRINTED: 04/17/2017 FORM APPROVED

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/17/2017 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	-	(X3) DATE S COMPL	SURVEY
		345278	B. WING		_	02/1	0/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S			
NORTHEF	RN SURRY SNF			830 ROCKFORD STREET MOUNT AIRY, NC 2703			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 333	resident's paper and e inquiry, the pharmacia had received the meter (instead of metoproloo readmitted to the facili this was apparently a indicated he would ne to determine whether dosing should be cha medication changed t given once daily. At the time of the inte PM, the consultant ph he wrote a note to the explaining the situatio Resident #33 was dis 1/11/17 after experien He noted the discharg discontinued the 25 m twice daily and ordere succinate to be given also noted the pharma provide 25 mg metop daily since the residen hospital. On 2/10/17 at 2:55 Pf (DON) and consultant Resident #33 's Physic telephone to clarify the dosing. A telephone interview at 3:00 PM with the P interview, the PA cont the order and reporter	the pharmacist reviewed the electronic chart. Upon st confirmed the resident oprolol tartrate formulation I succinate) since she was lity on 1/11/17 and reported in error. The pharmacist ed to contact the physician the metoprolol tartrate nged to twice daily or the or metoprolol succinate rview on 2/10/17 at 2:37 harmacist was observed as a resident ' s physician, on. The note indicated charged from acute care on noting a myocardial infarction. ge physician had ng metoprolol tartrate given ed 25 mg metoprolol once daily. The pharmacist acy had continued to rolol tartrate given once int ' s discharge from the M, the Director of Nursing t pharmacist contacted sician Assistant (PA) by e metoprolol order and	F 33	3			

Facility ID: 953376

If continuation sheet Page 30 of 52

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/17/2017 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		345278	B. WING			02/	10/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
NORTHER	N SURRY SNF				30 ROCKFORD STREET IOUNT AIRY, NC 27030		
							0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333		a 30 h once daily. Upon inquiry he resident may have had	F	333			
	an adverse effect from tartrate only once dail stated the answer wo 's symptomology. He	n receiving metoprolol y for the past month, the PA uld be based on the resident e reported the resident kay, and therefore the error					
F 356 SS=C	PM with the facility 's DON stated she would to be transcribed corre- discharge summary.	ducted on 2/10/17 at 4:45 DON. Upon inquiry, the d expect medication orders ectly from the hospital TED NURSE STAFFING	F	356			2/10/17
	483.35 (g) Nurse Staffing Info (1) Data requiremen the following informat	ts. The facility must post					
	(i) Facility name.						
	(ii) The current date.						
	by the following categ	aff directly responsible for					
	(A) Registered nurses	5.					
	(B) Licensed practical vocational nurses (as	l nurses or licensed defined under State law)					
	(C) Certified nurse aid	des.					

Facility ID: 953376

If continuation sheet Page 31 of 52

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 04/17/2017 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	
		345278	B. WING		02/	/10/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
NORTHER	N SURRY SNF		-	30 ROCKFORD STREET MOUNT AIRY, NC 27030		
(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 APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 356	Continued From page	31	F 356			
	(iv) Resident census.					
	(2) Posting requireme	ents.				
		ost the nurse staffing data h (g)(1) of this section on a inning of each shift.				
	(ii) Data must be post	ed as follows:				
	(A) Clear and readabl	e format.				
	(B) In a prominent pla residents and visitors	ace readily accessible to				
	The facility must, upo make nurse staffing d	posted nurse staffing data. n oral or written request, lata available to the public ot to exceed the community				
	facility must maintain staffing data for a min required by State law	tion requirements. The the posted daily nurse nimum of 18 months, or as , whichever is greater. is not met as evidenced				
	Based on observation interviews, the facility	ns, record review and staff failed to include all of the		F356		
	postings, including the	on the daily nursing staff e name of the facility, for 60 eviewed (12/9/16 through		Corrective action by placing logo with name was completed on 2-9-17 at 4 when notified by surveyor of deficient practice.	om	
	The findings included	:		Copies of staffing sheets will be suppleted to Robin Hodgin, VP of Patient Servi		
		on 2/7/17 at 11:15 AM affing information dated		daily 5 days a week x4 weeks to sho correction of deficient practice. Ong	W	

Event ID: 6XL911

Facility ID: 953376

If continuation sheet Page 32 of 52

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING		COMPLETED	
		B. WING	02/10/2017			
NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHERN SURRY SNF			٤ ا			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		ULD BE COMPLETI	
F 356	Continued From page	e 32	F 356			
	2/7/17 was posted in the hallway near the nursing station. The name of the facility was not included on the nursing staff posting.			random audits will be completed o month by VP of Patient Services.	nce a	
	An observation made on 2/8/17 at 8:30 AM revealed the nurse staffing information dated 2/8/17 was posted in the hallway near the nursing station. The name of the facility was not included on the nursing staff posting.			Monitoring will be reported to th QA committee meeting beginnin 2017 thru September 2017.		
	revealed the nurse st 2/9/17 was posted in	on 2/9/17 at 9:10 AM affing information dated the hallway near the nursing the facility was not included osting.				
	Director of Nursing (E	ducted with facility ' s DON) on 2/9/17 at 3:21 PM. he was not aware it was e facility name on the				
F 371 SS=F	staff postings from th	the nursing staff postings e name of the facility. D PROCURE,	F 371		3/1/17	
		rom sources approved or ry by federal, state or local				
		ood items obtained directly subject to applicable State ulations.				

Facility ID: 953376

If continuation sheet Page 33 of 52

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345278 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET NORTHERN SURRY SNF MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 371 Continued From page 33 F 371 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the F-371 facility failed to maintain sanitary conditions in the kitchen by not ensuring pans, and food slicing In-Services were held from 2/13/17-3/1/17 knives were stored/stacked clean and dry; and, for all dietary staff on proper cleaning by not ensuring food service equipment were procedures, including a review of the maintained clean and free from debris. policy, with emphasis on cleaning knives, meat slicer, grill, pots and pans, plate and Findings included: base warmer. To monitor the performance and to make 1. During the observation of the meal tray line sure solutions were sustained, the dietary service in the kitchen on 2/10/17 at 12:15pm, 2 of coordinator will conduct daily visual 2-plate warmers located next to the meal serving inspections of equipment prior to leaving line contained stained, dried brown debris on the each day. The dietary supervisor will inside where clean plates were stacked. Also conduct weekly inspections of the kitchen observed in the kitchen was a table top meat equipment and utensils to include knives, slicer. There were brown crumbs noted beneath meat slicer, grill, pots/pans, plate warmer the meat slicer. The DM revealed that the plate and base warmer for adequacy of warmers were cleaned weekly by the dietary staff cleaning. The weekly inspection will be and acknowledged the inside of both plate once every seven days on a random warmers were dirty. schedule for three months. Monitoring will be documented and reported to the QA

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 953376

If continuation sheet Page 34 of 52

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUTIOU			IO. 0938-039	
		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
345278			B. WING		02/10/2017		
NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
				330 ROCKFORD STREET MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		HOULD BE	(X5) COMPLETIO DATE	
F 371	Continued From page	e 34	F 371				
F 428	2. During the kitchen observation with the DM (Dietary Manager) on 2/10/17 at 12:20pm 4-large muffin tins and 2-large pans containing dried brown stains were stacked on the storage rack. Also, the knife rack contained 4-slicing knives that were stained with dried debris. The DM removed these items from storage to the three compartment sink, instructing staff to re-wash them. 483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW,		F 428				
SS=D	c) Drug Regimen Rev (1) The drug regimen reviewed at least onc						
	brain activities associ and behavior. These limited to, drugs in the (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	ug is any drug that affects ated with mental processes drugs include, but are not e following categories:					
	to the attending physic facility's medical direct and these reports mu (i) Irregularities include	ctor and director of nursing, st be acted upon. le, but are not limited to, any riteria set forth in paragraph					

Facility ID: 953376

If continuation sheet Page 35 of 52

						NO. 0938-039	
IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345278		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		· · ·	(X3) DATE SURVEY COMPLETED	
		B. WING		0	02/10/2017		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
				830 ROCKFORD STREET MOUNT AIRY, NC 27030			
(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 APPRI DEFICIENCY)		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 428	Continued From page 35 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,		F 4	28			
	and the irregularity th	e pharmacist identified.					
	resident's medical red irregularity has been action has been take be no change in the r	cord that the identified reviewed and what, if any, n to address it. If there is to nedication, the attending ument his or her rationale in					
	and procedures for th review that include, b frames for the different steps the pharmacist identifies an irregular to protect the residen This REQUIREMENT	develop and maintain policies the monthly drug regimen tut are not limited to, time nt steps in the process and must take when he or she ity that requires urgent action t.					
	by: Based on record reviews, and staff and pharmacist interviews, the consultant pharmacist failed to identify and address a Gradual Dose Reduction (GDR) for an antidepressant			F428 Plan of Correction			
	(citalopram), an antia hypnotic (temazepam	nxiety (lorazepam), and a n) medication ordered for 1 ts reviewed for unnecessary		Dose reductions for Loraze Temazepam, and Citalopran initiated for resident #27 on Scheduled Lorazepam dose on 3/6/17.	m were 02/10/17.		
	The findings included: Resident #27 was admitted to the facility on			Audit was completed on 2-1 pharmacist for those reside			
	7/9/15. Her cumulative diagnoses included Generalized Anxiety Disorder (GAD),			potential to be affected by the deficient practice.	ne alleged		

Event ID: 6XL911

Facility ID: 953376

If continuation sheet Page 36 of 52

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345278	B. WING		02/10/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
NORTHEF	RN SURRY SNF			830 ROCKFORD STREET MOUNT AIRY, NC 27030	
(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 APPR DEFICIENCY)	JLD BE COMPLETIO
F 428	Continued From page	e 36	F 42	8	
	included the following (mg) haloperidol (an a given as two tablets b anxiety/agitation; 20 r given as one tablet by lorazepam given as o daily; 1 mg lorazepam needed for anxiety; a as one capsule by mo A review of Resident revealed the facility ' completed monthly M on the following dates On 3/22/16, the resi the following medicat and lorazepam for an for Generalized Anxie temazepam for insom mirtazapine (an antid recently discontinued to psychotropic medicat psychotropic medicat brain activities associ and behavior. Psych antipsychotic, antidep hypnotic medications On 4/18/16, no char medications were not	#27 ' s March 2016 revealed her medications orders, in part: 1 milligram antipsychotic medication) by mouth every 6 hours for milligrams (mg) citalopram y mouth once daily; 1 mg one tablet by mouth twice in given every two hours as nd 15 mg temazepam given both every night at bedtime. #27 ' s medical record s consultant pharmacist redication Regimen Reviews s: dent was noted to receive ions, in part: haloperidol xiety/agitation, citalopram ety Disorder (GAD), and maia. The pharmacist noted epressant) had been . No other changes related cations were noted at that lations regarding ions were made. A ion is any drug that affects ated with mental processes otropic medications include pressant, antianxiety, and mges related to psychotropic red. No recommendations ic medications were made. ntenance medication		To protect residents in similar situal and ensure problem does not recu regimens for each resident are rev each month by the pharmacist. Pharmacist will recommend gradual reduction attempts at this time alor the discontinuation of unnecessary medications. A monitoring tool has employed by the pharmacist to aid tracking gradual dose reductions of sedative/hypnotics, anti-anxiety ag and antipsychotic medications. Pharmacist will attend weekly care meetings and discuss resident's medication therapy with special att focused on gradual dose reduction above mentioned medications. Discussion to include, but not limite medication name and current dose date of last gradual dose reduction attempt, and (3) whether the dose reduction trial is successful or not. care plan meeting it is found that a gradual dose reduction attempt of the above mentioned medications occurred in the past quarter, then pharmacist will initiate a request fo dose reduction to the attending phy that day. The MDS Coordinator will determine which residents are sche for the weekly care plan meetings, 100% of residents care planned at once every 90 days. Pharmacist w attend monthly Quality Assurance Meetings where gradual dose reduction	r iewed al dose ng with / s been in f eents, e-plan tention is of ed to 1) p, (2) f f, at any of has not vir a ysician ill eduled with least vill also uction

Facility ID: 953376

If continuation sheet Page 37 of 52

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345278 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET NORTHERN SURRY SNF MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 428 Continued From page 37 F 428 --On 6/21/16, no maintenance medication provider and tracked on enclosed form. changes were noted. There were no Documentation of dose reductions will be recommendations made at this time. placed in the resident's medical record. --On 7/20/16, no changes related to psychotropic medications were noted. There were no Monitoring of compliance will be reported recommendations made at this time. monthly beginning in March 2017 thru --On 8/19/16. the consultant pharmacist noted February 2018 to QA Committee. haloperidol was added at 2 mg scheduled twice daily during the past month. No other medication DON will review residents drug regimens changes were noted to have been made within for unnecessary drugs and documented the last 60 days. No recommendations were attempts at gradual dose reduction on made at this time. monthly basis. --On 9/26/16, the consultant pharmacist notes indicated no maintenance medication changes had been made in the past 30 days. No recommendations were made at this time. --On 10/18/16, no medication changes were noted to have been made within the last 60 days. No recommendations were made at this time. On 10/26/16, the consultant pharmacist wrote an Observation/Recommendation Note for Resident #27 's physician which read: "CMS (Centers for Medicare & Medicaid Services) requires gradual dose reduction trials for antipsychotic medications. (Resident #27) is currently getting haloperidol 2 mg po (by mouth) BID (twice daily) (scheduled). She has been on this dose since July. Can a dose reduction trial of 1 mg po BID be initiated or if not could you please provide a clinical note as to why?" A review of the resident ' s medical record revealed the physician agreed with the pharmacist 's recommendation and reduced the dose of haloperidol from 2 mg to 1 mg given twice daily. Further review of Resident #27 's medical record revealed the facility 's consultant pharmacist completed additional monthly Medication

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/17/2017

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 // APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	
		345278	B. WING			02/	10/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHER	N SURRY SNF				30 ROCKFORD STREET IOUNT AIRY, NC 27030		
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	Resident #27 ' s halog from 2 mg to 1 mg by adverse behaviors no reduction. No other m made in the past 30 d were made at this tim On 12/26/16, no advest since the haloperidol maintenance medicat the past month and m made at this time. On 1/18/16, no advest since the haloperidol maintenance medicat the past month and m made at this time. On 1/18/16, no advest since the haloperidol maintenance medicat the past month and m made at this time. A review of Resident to Data Set (MDS) dated resident had moderat for daily decision mak with eating, required I for her bed mobility at required extensive as toileting. Section E o resident did not exhib rejection of care. A review of Resident to Physician ' s Orders m included the following be given as one table mg citalopram given at daily; 1 mg lorazepam mouth twice daily; 1 m two hours as needed	the following dates: nsultant pharmacist noted beridol dose was reduced mouth twice daily with no ted since the dose nedication changes were lays. No recommendations e. verse behaviors were noted dose reduction. No ion changes were made in o recommendations were erse behaviors were noted dose reduction. No ion changes were made in o recommendations were #27 ' s quarterly Minimum d 1/18/17 revealed the ely impaired cognitive skills ting. She was independent imited assistance from staff nd personal hygiene, and sistance for dressing and f the MDS indicated the it any behaviors nor	F	428			

Facility ID: 953376

If continuation sheet Page 39 of 52

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 1 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	ECONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345278	B. WING		_	02/	10/2017
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
NORTHER	N SURRY SNF			30 ROCKFORD STREET	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428		e 39 sident #27 ' s medical record o documentation of GDRs	F 428				
	having been addresse lorazepam, or temaze	ed for the citalopram, epam currently prescribed.					
	PM with the facility 's Upon inquiry, the pha expect to address GD temazepam every 3-4	ducted on 2/10/17 at 2:09 consultant pharmacist. rmacist reported he would DRs for lorazepam and a months, and an as citalopram "less often"					
	at 4:30 PM with the co that time, the pharma his records and found attempted at any time lorazepam, nor temaz Resident #27. The pl already telephoned the received new medica When asked if the new #27 's GDRs for the co	e for the citalopram, zepam prescribed for harmacist reported he had					
	Note written by the co 2/10/17 for Resident a actions taken and new received from the resi "Leave scheduled lo Decrease PRN (as r mg po (by mouth);	ident ' s PA: prazepam as is; needed) lorazepam to 0.5 am to 7.5 mg po q HS (every					

Facility ID: 953376

If continuation sheet Page 40 of 52

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 APPROVED ). 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		345278	B. WING		_	02/	10/2017	
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
NORTHER	N SURRY SNF			30 ROCKFORD STREET	0			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 428 F 431	PM with the facility 's A review of Resident a psychotropic medicati addressed was discus DON stated she would monitored and addres would expect a discus physician and docume GDRs made, or altern documented as to wh made.	n to 10 mg po daily." ducted on 2/10/17 at 4:45 Director of Nursing (DON). #27 's history of tons without GDRs ased. Upon inquiry, the d expect GDRs to be ased. She indicated she astor to be held with the ented attempts for the natively, a reason y the attempts could not be	F 428 F 431				3/3/17	
SS=D	LABEL/STORE DRUG The facility must providurings and biologicals them under an agreen §483.70(g) of this par- unlicensed personnel law permits, but only of supervision of a license (a) Procedures. A face pharmaceutical service that assure the accurate dispensing, and admini- biologicals) to meet the (b) Service Consultation employ or obtain the se pharmacist who (2) Establishes a systed disposition of all controls	GS & BIOLOGICALS ide routine and emergency to its residents, or obtain ment described in t. The facility may permit to administer drugs if State under the general sed nurse. cility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and he needs of each resident. on. The facility must						

Facility ID: 953376

If continuation sheet Page 41 of 52

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 // APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	
		345278	B. WING			02/	10/2017
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
NORTHER	N SURRY SNF				30 ROCKFORD STREET		
					IOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 431	Continued From page	÷ 41	F	431			
	(3) Determines that du that an account of all maintained and period						
		a used in the facility must be with currently accepted s, and include the y and cautionary					
	the facility must store locked compartments	n State and Federal laws, all drugs and biologicals in under proper temperature only authorized personnel to					
	permanently affixed c controlled drugs listed Comprehensive Drug Control Act of 1976 at abuse, except when t package drug distribu quantity stored is min be readily detected. This REQUIREMENT by:	provide separately locked, ompartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can			F431		
	interviews, the facility when opened to allow shortened expiration of storage room and 1 o for Rooms 337-352); medications as specifi	failed to date a medication / for the determination of its date in 1 of 1 medication f 2 medication carts (Cart 2 and, failed to store			Corrective action for the residents affected by the alleged deficient practi Resident #4 had no negative outcome related to deficient practice. Nursing staff educated on labeling foil		

Facility ID: 953376

If continuation sheet Page 42 of 52

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345278 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET NORTHERN SURRY SNF MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 431 Continued From page 42 F 431 for Rooms 320-336 and Cart 2 for Rooms packages with date when opened and 337-352). storing budesonide inhalation suspension in upright position was completed by DON The findings included: on 3/3/17. New nurses will be educated on the opening and storage of budesonide 1) Accompanied by Nurse #2, an observation of inhalation suspension in upright position the medication store room was made on 2/9/17 at by DON/Designee. Pharmacy was 5:00 PM. The observation revealed a carton of notified of medication not being stored 0.25 mg / 2 ml budesonide inhalation suspension properly prior to survey team exit. (a corticosteroid medication to be inhaled via use of a nebulizer) dispensed for Resident #4 was Audit of medication cart for packages stored on a shelf in the medication room. The opened that require opened date to be carton included an opened foil pouch containing 4 completed daily x2 weeks then 3x a week vials of inhalation suspension. The manufacturer for 6 weeks for a total of 8 weeks to be labeling of the budesonide inhalation suspension completed by DON/Designee. included storage instructions which read, in part: "Once the foil envelope is opened, use the vials Audit of medication cart for medications within 2 weeks." The foil pouch was not dated. that are required to be stored in a standing position will be completed daily A review of Resident #4 's Physician Orders x2 weeks and then 3x a week for 6 weeks revealed there was a current order for for a total of 8 weeks to be completed by DON/Designee budesonide 0.25 mg / 2 ml inhalation suspension to be given as one vial via nebulizer twice daily. Monitoring of compliance will be reported An interview was conducted on 2/9/17 at 5:05 PM to the next monthly QA committee with Nurse #2. When asked how she would know meeting beginning on March 2017 thru when the foil pouches of budesonide inhalation May 2017. suspension had been opened. Nurse #2 stated she would not know. F431 An interview was conducted on 2/10/17 at 4:45 Corrective action for the residents PM with the Director of Nursing (DON). During affected by the alleged deficient practice. Resident #30 had no negative outcomes the interview, the DON reported she would expect pharmacy to make nursing staff aware of any related to deficient practice. special storage needs for medications. Nursing staff educated on proper storage 2) An observation of the medication cart for of Pred Forte 1% ophthalmic suspension Rooms 337-352 was made on 2/9/17 at 4:50 PM. was completed by DON. New nurses will The observation revealed one vial of 0.25 mg / 2 be educated on the storage of Pred Forte

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

Facility ID: 953376

If continuation sheet Page 43 of 52

PRINTED: 04/17/2017

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345278 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET NORTHERN SURRY SNF MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 431 Continued From page 43 F 431 ml budesonide inhalation suspension (a 1% ophthalmic suspension. Pharmacy corticosteroid medication to be inhaled via use of was notified of medication not being a nebulizer) was stored in an opened foil pouch stored properly prior to survey team exit. laying on its side in the medication cart drawer Audit of medication cart for medications labeled for Resident #4. The manufacturer labeling of the budesonide inhalation suspension that are required to be stored in a included storage instructions which read, in part: standing position will be completed daily "Store unopened vials in the foil envelope placed x2 weeks and then 3x a week for 6 weeks upright in the carton ... Once the foil envelope is for a total of 8 weeks to be by opened, use the vials within 2 weeks." The foil DON/Designee. pouch was not stored upright; and, the foil pouch was not dated to indicate when it had been Monitoring of compliance will be reported opened. to the next monthly QA committee meeting beginning March 2017 thru May A review of Resident #4 's Physician Orders 2017. revealed there was a current order for budesonide 0.25 mg / 2 ml inhalation suspension to be given as one vial via nebulizer twice daily. An interview was conducted on 2/9/17 at 5:05 PM with Nurse #2 after observations of both the medication cart (Rooms 337-352) and medication storage room were conducted. When asked how she would know when the foil pouches of budesonide inhalation suspension had been opened. Nurse #2 stated she would not know. Nurse #2 also indicated she was not aware the vials of budesonide inhalation suspension needed to be stored upright. An interview was conducted on 2/10/17 at 4:45 PM with the Director of Nursing (DON). During the interview, the DON reported she would expect pharmacy to make nursing staff aware of any special storage needs for medications. 3) An observation of the medication cart for Rooms 320-336 was made on 2/9/17 at 4:25 PM. The observation revealed 1 - 10 milliliter (ml)

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 44 of 52

PRINTED: 04/17/2017

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	_	(X3) DATE	
		345278	B. WING			02/	10/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S			
NORTHER	N SURRY SNF			830 ROCKFORD STREET MOUNT AIRY, NC 2703			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431 F 520 SS=E	corticosteroid suspense dispensed for Resider down on its side in a c cart. The manufactur storage were covered Upon peeling back the manufacturer 's label Forte 1% ophthalmic s and read, in part: "Ste A review of Resident s revealed there was a 1% ophthalmic suspe drop in the right eye of An interview was cone with Nurse #3. Nurse medication cart for Ro interview, Nurse #3 re Pred Forte eye drops need to find an alterna drops. An interview was cone PM with the Director of the interview, the DOI pharmacy to make nu special storage needs 483.75(g)(1)(i)-(iii)(2)( COMMITTEE-MEMBE QUARTERLY/PLANS	% ophthalmic suspension (a sion used as an eye drop) ht #30 was stored laying drawer of the medication er 's instructions for by the pharmacy labeling. e pharmacy label, the ing on the bottle of the Pred suspension became visible ore in upright position." #30 's Physician Orders current order for Pred Forte nsion to be given as one nce daily. ducted on 2/9/17 at 4:30 PM #3 was assigned to the poms 320-336. During the eviewed the labeling on the and reported she would ative way to store these eye ducted on 2/10/17 at 4:45 of Nursing (DON). During N reported she would expect rsing staff aware of any for medications. i)(ii)(h)(i) QAA ERS/MEET ht and assurance. ntain a quality assessment	F 4				3/3/17

Facility ID: 953376

If continuation sheet Page 45 of 52

	-	ID HUMAN SERVICES			FORM	D: 04/17/2017
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		345278	B. WING		02/	10/2017
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHER	N SURRY SNF			30 ROCKFORD STREET IOUNT AIRY, NC 27030		
(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 APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 520	Continued From page	: 45	F 520			
	(i) The director of nurs	sing services;				
	(ii) The Medical Direct	tor or his/her designee;				
	(iii) At least three othe staff, at least one of w	er members of the facility's vho must be the				
	administrator, owner, individual in a leaders	a board member or other ship role; and				
	(g)(2) The quality asso committee must :	essment and assurance				
	(i) Meet at least quarter coordinate and evaluat identifying issues with assessment and assu- necessary; and	ate activities such as respect to which quality				
		ement appropriate plans of ified quality deficiencies;				
	Secretary may not rec records of such comm such disclosure is rela	mation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this				
	(i) Sanctions. Good fa committee to identify a deficiencies will not be sanctions. This REQUIREMENT by:	and correct quality				
	Based on record revi facility staff, the facility	ew and interviews with the y's Quality Assessment and mmittee failed to maintain		F520 Deficiencies in the areas of		
		ires and monitor these		comprehensive care plan developme	ent,	

Facility ID: 953376

If continuation sheet Page 46 of 52

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	NO. 0938-039
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COI	MPLETED
		345278	B. WING		0	2/10/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHE	RN SURRY SNF			830 ROCKFORD STREET MOUNT AIRY, NC 27030		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 520	interventions that the March of 2016. This deficiencies which we February of 2016 on a subsequently recited survey. The deficien comprehensive care care plan revision (F2 (F329), medication re- labeling/storage of me continued failure of th surveys of record sho inability to sustain an Program. The findings included This tag is cross refer a) F279: Develop Co Based on observation interviews, the facility comprehensive care residents (Resident # motion; and, for 2 of 3 and #30) reviewed fo During the recertificat facility was cited for F care plan with critical monitoring target beh non-pharmacological residents receiving ps (Resident #12). On th survey, the facility wa develop a care plan to	committee put into place in was for five recited ere originally cited in a recertification survey and on the current recertification ncies were in the areas of plan development (F279), 280), unnecessary drugs egimen review (F428), and edications (F431). The ne facility during two federal ow a pattern of the facility 's effective Quality Assurance I: rred to: omprehensive Care Plans. ns, record reviews, and staff of failed to develop a plan for 1 of 3 sampled 30) reviewed for range of 3 sampled residents (#29 r activities. tion survey of 2/19/16, the 5279 for failure to develop a interventions, including naviors and interventions, for 1 of 6 sychotropic medications he current recertification	F 52		d s was ers of the mpliance oped to red and with I. These a item at of QA quarterly 2017 and will be ing quarterly t of lopment, y drugs, pel/storage	

If continuation sheet Page 47 of 52

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/17/2017 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		345278	B. WING			02/	10/2017
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
NORTHER	N SURRY SNF				330 ROCKFORD STREET MOUNT AIRY, NC 27030		
(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 APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 520	PM with the facility 's and Vice President (V areas of recited defici current recertification during the interview. Committee has been plans since 11/7/16, v reviewed on a quarter the last staff meeting attendance) emphasis on care plans. Addition residents ' care plans November and Decer at the QAA meeting on DON stated the care specifically address a itself was described at b) F280: Care Plan F observation, record re the facility failed to re residents reviewed for (Resident #16).	ducted on 2/10/17 at 5:30 c Director of Nursing (DON) /P) of Patient Services. The encies identified by the survey were discussed The DON reported the QAA working on the area of care vith care plans being rly basis. The DON stated (held on 1/5/17 with 90% zed the need for staff input onally, the DON noted s completed in October, nber of 2016 were reviewed n 1/19/17. Upon inquiry, the plan QAA project did not timeline and the action plan is, "ongoing."	F	520			
	care plan with the cur medications and dosa receiving psychotropi #16). On the current facility was recited for	280 for failure to update a rent psychotropic ages for 1 of 6 residents c medications (Resident recertification survey, the failing to revise the care viewed for significant weight					
	PM with the facility 's and Vice President (V	ducted on 2/10/17 at 5:30 Director of Nursing (DON) (P) of Patient Services. The encies identified by the					

If continuation sheet Page 48 of 52

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/17/2017 M APPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345278	B. WING			02	/10/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHER	RN SURRY SNF				830 ROCKFORD STREET MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	during the interview. Committee has been plans since 11/7/16, v reviewed on a quarter the last staff meeting attendance) emphasiz on care plans. Addition residents ' care plans November and Decer at the QAA meeting on DON stated the care of specifically address a itself was described an c) F329: Drug Regin Unnecessary Drugs. and staff and pharman failed to identify and a Reduction (GDR) or conneed for an antidepre antianxiety (lorazepar (temazepam) medicat sampled residents rev drugs (Resident #27). During the recertificat facility was cited for F Resident #12's drug r unnecessary drugs, a monitor target behavior dose reduction of an a 1 of 6 residents. On t survey, the facility wa and attempt a GDR, of continued need for an and hypnotic medicat	survey were discussed The DON reported the QAA working on the area of care with care plans being rly basis. The DON stated (held on 1/5/17 with 90% zed the need for staff input onally, the DON noted is completed in October, mber of 2016 were reviewed in 1/19/17. Upon inquiry, the plan QAA project did not timeline and the action plan is, "ongoing." Then is Free From Based on record reviews, cist interviews, the facility attempt a Gradual Dose document the continued ssant (citalopram), an m), and a hypnotic tion ordered for 1 of 5 viewed for unnecessary tion survey of 2/19/16, the 329 for failure to ensure that egimen was free of is they failed to identify and ors and failed to attempt a antipsychotic medication for the current recertification s recited for failing to identify or document the resident 's a antidepressant, antianxiety,	F	520			

If continuation sheet Page 49 of 52

		MEDICAID SERVICES		ייסוד		(X3) DATE	D. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	· /	PLETED	
		345278	B. WING			02	/10/2017	
NAME OF P	ROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP CODE			
NORTHEF	RN SURRY SNF				830 ROCKFORD STREET MOUNT AIRY, NC 27030			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIOI DATE	
F 520	and Vice President ( areas of recited defic current recertification during the interview. reported a spread she into place by the cons facility 's last recertifi of unnecessary media reductions. Data fror was reviewed by the QAA committee quart d) F428: Medication on record reviews, ar interviews, the consu- identify and address a (GDR) for an antidep antianxiety (lorazepai (temazepam) medica sampled residents re- drugs (Resident #27) During the recertificat facility was cited for F consultant pharmacis dose reduction and/o rationale for the conti medication for 1 of 6 unnecessary medicat current recertification recited for the consul- identify and address a continuing to receive antianxiety, and hyper	s Director of Nursing (DON) /P) of Patient Services. The iencies identified by the survey were discussed Upon inquiry, the DON eet was developed and put sultant pharmacist after the ication to address the areas cations and gradual dose in the information collected DON and reported to the terly. Regimen Review. Based ind staff and pharmacist ltant pharmacist failed to a Gradual Dose Reduction ressant (citalopram), an m), and a hypnotic tion ordered for 1 of 5 viewed for unnecessary tion survey of 2/19/16, the 5428 for failure of the st to recommend a gradual r a risk versus benefit nued use of an antipsychotic residents reviewed for tions (Resident #12). On the survey, the facility was tant pharmacist failing to a GDR for a resident an antidepressant,	F	520				
		s Director of Nursing (DON) /P) of Patient Services. The						

Facility ID: 953376

If continuation sheet Page 50 of 52

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM A	04/17/2017 PPROVED )938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,				) DATE SU COMPLE	RVEY
		345278	B. WING				02/10	/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
NORTHER	RN SURRY SNF				830 ROCKFORD STREET MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	C	(X5) COMPLETION DATE
F 520	current recertification during the interview. reported a spread she into place by the cons facility 's last recertifi of unnecessary medic reductions. Data from was reviewed by the I QAA committee quart e) F431: Labeling ar on observation, recor- interviews, the facility when opened to allow shortened expiration of storage room and 1 o for Rooms 337-352); medications as specifi manufacturer in 2 of 2 for Rooms 320-336 at 337-352). During the recertificat facility was cited for F expired medication for carts and failure to da when opened in one of On the current recertificat shortened expiration of medications as specifi manufacturer. An interview was com- PM with the facility 's and Vice President (V	encies identified by the survey were discussed Upon inquiry, the DON eet was developed and put sultant pharmacist after the cation to address the areas cations and gradual dose in the information collected DON and reported to the erly. and Storage of Drugs. Based d review and staff failed to date a medication of or the determination of its date in 1 of 1 medication f 2 medication carts (Cart 2 and, failed to store fied by the drug 2 medication carts (Cart 1 and Cart 2 for Rooms ion survey of 2/19/16, the 431 for failure to remove an om one of two medication the a multi dose insulin vial of one medication rooms. fication survey, the facility to date medications when e determination of a date; and, for failing to store	F	520				

Facility ID: 953376

If continuation sheet Page 51 of 52

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345278		345278	B. WING			02/10/2017		
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE			
NORTHERN SURRY SNF			830 ROCKFORD STREET MOUNT AIRY, NC 27030					
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE	
F 520	current recertification during the interview. reported the deficience labeling and storage recertification had mo medications. She inc labeling/storage conc	survey were discussed Upon inquiry, the DON cy related to medication from the facility ' s last	F	52				

Facility ID: 953376

If continuation sheet Page 52 of 52