PRINTED: 06/07/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345191	B. WING _				29/2017	
	ROVIDER OR SUPPLIER DMMUNITY HEALTH AN	ND REHAB CENTER		542	EET ADDRESS, CITY, STATE, ZIP CODE ALLRED MILL ROAD UNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 166 SS=C	(j)(2) The resident hamust make prompt of grievances the reside with this paragraph. (j)(3) The facility must of file a grievance or resident. (j)(4) The facility must of ensure the prompt regarding the reside paragraph. Upon reda copy of the grievance policy must of the grievance policy must of the grievance policy must of the grievance sanonymous of the grievance office can be filed, that is, address (mailing and number; a reasonab completing the reviet to obtain a written degrievance; and the control of the grievance of the grievance; and the control of the grievance of th	as the right to and the facility efforts by the facility to resolve lent may have, in accordance st make information on how complaint available to the st establish a grievance policy tresolution of all grievances nts' rights contained in this quest, the provider must give nce policy to the resident. The	F	166			5/29/17	
ABORATORY	DIRECTOR'S OR PROVIDER	NSUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE	

Electronically Signed 05/22/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C 04/29/2017		
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F 166	by the facility; maintinformation associal example, the identity grievances submitted written grievance decoordinating with stancessary in light of (iii) As necessary, to prevent further poteright while the allegatinvestigated; (iv) Consistent with reporting all alleged abuse, including injurand/or misappropriation furnishing subject provider, to the admass required by States (v) Ensuring that all include the date the summary statement the steps taken to insummary of the per regarding the residents to whether the great the great to whether the great the g	g any necessary investigations raining the confidentiality of all ted with grievances, for y of the resident for those and anonymously, issuing recisions to the resident; and rate and federal agencies as a specific allegations; raking immediate action to action to another ted violations of any resident red violation is being §483.12(c)(1), immediately violations involving neglect, raise of unknown source, ration of resident property, by revices on behalf of the hinistrator of the provider; and	F1	66				

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	ROVIDER OR SUPPLIER	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	•	5 1/20/20 11
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 166	confirms a violation rights within its area (vii) Maintaining evice result of all grievance 3 years from the issedecision. This REQUIREMENT by: Based on staff interfacility's grievance persident's right to file and the contact inform official including the business address at Findings included: A review of the facilititled "Truly Listening was provided by the 4/28/17. The policy stated "Touncerns submitted member of the facilitiant acts as the Grievand resident's legal reprinterested person has should encourage as	ge 2 al law enforcement agency for any of these residents' of responsibility; and dence demonstrating the ces for a period of no less than uance of the grievance IT is not met as evidenced rviews and record review, the colicy failed to include the e grievances anonymously rmation of the grievance ir name, physical and e-mail and business phone number. Ity policy dated 2/2017 and g to Our Customers Program" e social worker (SW) on The facility actively resolves orally or in writing to any ty's staff. The Administrator ce Official. 1. If a resident, a esentative, or another as a concern, a staff member and assist the resident, or e resident's behalf to file a	F 1	Please accept this Plan of Con (POC) as Surry Community He Rehabilitation Center's credible of compliance. Preparation and of this POC does not constitute or agreement with the findings noncompliance. The POC is being provided purederal ad State requirements require an acceptable Plan of as a condition of continued ceres as a condition of cont	ealth and e allegation nd execution e admission of rsuant to s which Correction rtification. ot Efforts to ices r of Policy ons ffairs aware effective ected in the fically, the	n
	Form. 2. If the facil staff should docume Concern Form. 3. should acknowledge immediately notify the staff of	the facility using the Concern lity receives a concern orally, ent the concern using the Staff receiving the concern e receipt of concern, he Grievance Official and cion. 4. If the concern may be		resident's right to file grievance anonymously. (b) A notice was immediately puthe Family Board in the front longer to the front longer to the first providents, family, and state contact information of the grieval official including their name, pl	posted on obby to aff of the vance	

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NAME OF F	COVIDER OR SUFFLIER						
SURRY CO	OMMUNITY HEALTH AN	D REHAB CENTER		542 ALLRED MILL ROAD			
				MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 166	Continued From pag	e 3	F 16	6			
F 166	resolved immediately guidance of the Griethe concern and doc Concern Form. 5. A investigated and reserceipt of the concern. The Grievance Officiteam will designate at The investigator will of the concern to cordocument his or her Concern Form, and to the Grievance Officite within 24 hours, the the findings with the inter-disciplinary team a resolution. 6. The the individual filling that as soon as possible after receipt of the corresident or a resident Grievance Official will using the Concern Discrevance Official for appropriate corrective concern. 8. The Grievance of the individual filling after the initial follow concern is addressed.	y, the staff, under the vance Official, will resolve ument the resolution on the all other concerns are olved within 72 hours from n. al and the inter-disciplinary an investigator. have 2 days following receipt inplete the investigation, conclusions using the forward the completed form cial. Grievance Official reviews investigator and the m, as required, to determine Grievance Official informs are concern of the resolution but not longer than 72 hours oncern. Upon request by a t's legal representative, the II issue a concern decision ecision Form. 7. The	F 16	e-mail business address and busing phone number. 2. (a) A notice was posted on the Board in the front lobby to notify refamily, and staff of the resident's refile a grievance anonymously. Maintenance will install a Concernear the Family Board in the front for anonymous concerns. This winchecked daily Monday Friday by Grievance Official or designee. A informing residents they have the file a grievance anonymously has placed in each resident's room to residents are aware of their right the grievance anonymously, as well a location of the Concern Box. (b) Grievance Official posting was on Family Board in front lobby. A this posting was also placed in earesident's room, and a copy was reach resident's responsible party. Of the Grievance Official Posting was be given to Family Council Presidenting on 05/17/2017. 3. (a) A copy of the notice was placed resident's room to ensure reare aware of their right to file a grievance monymously, as well as the locat the Concern Box. Staff will be re-educated on Facility Grievance and notice stating residents have to file a grievance anonymously, the location of Concern Box near the Board in the front lobby for anonymously. Random audits will be	Family esidents, right to a Box lobby II be y the notice right to been ensure o file a s the placed copy of ch mailed to A copy vill also ent in a sidents evance ion of Policy the right he Family		
	when they entered the A review of the facility	ne facility.		completed on 5 residents per hall residents total) by Director of Nurs Assistant Director of Nursing, or d	sing,		

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		345191	B. WING _				C 29/2017
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0-1/	23/2017
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F 166 F 244 SS=C	which stated, "It is the support each resident and to ensure that aft received, the facility wand communicate the resident and/or reside manner. The Administresponsible for the reand/or issues. Any rerepresentative, family appointed advocate in fear of threat or reprisand issues are invest documented." An interview with the 3:00 PM revealed he required components were not reflected in the stated his expectarequired information pincluded in the policy. 483.10(f)(5)(iv)(A)(B) GRIEVANCE/RECOM (f)(5) The resident haparticipate in resident (iv) The facility must desident or family grothe grievances and resident resident or family grothe grievances and resident resi	titled "Concerns and Issues" e policy of the facility to t's right to voice concerns eer a concern has been will actively resolve the issue e resolution's progress to the ent's family in a timely strator is ultimately solution of all concerns esident, his or her member, employee, or may file a concern without sal in any form. All concerns igated, resolved and Administrator on 4/29/17 at was not aware that the effective November 2016 the facility grievance policy. etion was that all the pertaining to grievances be c. LISTEN/ACT ON GROUP MMENDATION s a right to organize and	F 1		to ensure residents are aware of their right to file a grievance anonymously, a the location of the Concern Box weekly 4 weeks, then monthly x 3, or until no further issues noted. (b) A copy of the Grievance Official posting will be placed in each resident's room. Staff will also be re-educated regarding the Grievance Official. Randweekly audits will be completed on 5 residents per hall by Director of Nursing. Assistant Director of Nursing, or design to ensure residents are aware of who the Grievance Official is, and how to get in touch with him weekly x 4 weeks, the monthly x 3, or until no further issues noted. 4. All results will be brought to QAPI x 3 months, or until no further issues noted.	x s dom g, nee he nen	5/29/17
	(A) The facility must be response and rational	ne able to demonstrate their le for such response.					

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F 244	(B) This should not be facility must impleme request of the resident This REQUIREMENT by: Based on resident are review of Resident C failed to effectively concept to address consumer which were voiced in meetings. Findings included: Resident #18 admitted diagnoses of chronice	e construed to mean that the nt as recommended every nt or family group. is not met as evidenced and staff interviews and puncil minutes, the facility ammunicate the facility's neerns about nurse staffing the Resident Council	F 2		ed s. nt		
	(MDS) assessment d Resident #18 had cle understood/understal intact. The Resident Counci reviewed from Decen The Resident Counci revealed there was n the halls and not eno dining rooms. The Resident Counci revealed the nursing rooms on time and th themselves.	I Meeting minutes were aber 2016-April 2017. I minutes dated 12/27/16 of enough nursing staff on ugh nursing staff in the I minutes dated 2/7/17 staff was not in the dining		work for 6 weeks at a time to schedules. Also discussed we have submitted a compereview to corporate for review 2. All concerns voiced during Council Meeting will be listed. Resident Council Concern Form and presented to the Council President for review resolution of grievances, Act Director will review with Respresident to ensure satisfact results. 3. Director of Nursing or Assof Nursing will audit and review Council Concern Follow-Up x 3 months to ensure all colbeing addressed, followed at Resident Council President reviewed at next Resident Compered Concerns Concerns Council Concerns Counci	to help cover with her that ensation ew. Ing Resident ed on the Follow-Up Resident w. Upon ctivities sident Councition with sistant Director were Resident of Form monthly neems are up on with the tight as well as	il or t ly	

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				54	42 ALLRED MILL ROAD		
SURRY C	OMMUNITY HEALTH AN	D REHAB CENTER		M	OUNT AIRY, NC 27030		
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F 244	Continued From page	nued From page 6					
	revealed there was "r nursing staff in the di	not enough help" and no ning room.			Meeting. 4. All results will be brought to QAPI x months, or until no further issues noted		
	The Resident Council minutes dated 4/11/17 revealed the nursing staff was not in the dining room. An interview was completed with Resident #18 on 4/29/17 at 9:37 AM. She stated the issues with staffing were discussed in Resident Council meetings, including that there was not enough nursing staff on the halls. Resident #18 reported that the facility had not specifically addressed ways they were resolving the issues the Resident Council brought up in the meetings.						
	Director on 4/29/17 a that a nursing repress Resident Council mer concerns with the Cowrote down their comdepartment itself wro discussed, they may, An interview was con Nursing (DON) on 4/2 stated she had been Council meetings on went in and talked to concerns." The DON any documentation to concerns were addressed.	they may not, I'm not sure." Inpleted with the Director of 29/17 at 10:39 AM. She to the last two Resident 3/21/17 and 4/11/17. "We them and addressed their reported she did not have a show how the Council's ssed. She stated if she ag schedule with her staff,					
		rview with the DON on he stated she thought the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING			l	C 29/2017
	DER OR SUPPLIER	D REHAB CENTER		54	TREET ADDRESS, CITY, STATE, ZIP CODE 42 ALLRED MILL ROAD IOUNT AIRY, NC 27030	,	-0.2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
Ac ho DC fro An Ad his	w concerns were b DN had not docume m the Resident Co interview was com ministrator on 4/29 expectation was the	d recorded on the minutes eing addressed and the ented any kind of follow up uncil. Inpleted with the 1/17 at 4:10 PM. He stated hat any concerns brought up cil meeting would be	F	244			
SS=D PA 48 (c) ani pla (i) inc be rec rev (ii) exi am oth pla (iv) inc (v) rig of (c)	RTICIPATE PLANI 3.10 (2) The right to part d implementation of an of care, including The right to particip cluding the right to i included in the pla quest meetings and visions to the perso The right to partici pected goals and o nount, frequency, a ner factors related to an of care. The right to receively and the plan of the right to see the ht to sign after sign care. (3) The facility sha	pate in the planning process, dentify individuals or roles to nning process, the right to at the right to request in-centered plan of care. pate in establishing the nutcomes of care, the type, and duration of care, and any to the effectiveness of the	F	280			5/29/17

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	(i) Facilitate the incl resident representa (ii) Include an assess strengths and need (iii) Incorporate the cultural preferences 483.21 (b) Comprehensive (2) A comprehensive (i) Developed withing the comprehensive (ii) Prepared by an includes but is not limited. (A) The attending position (B) A registered number of form of the resident. (C) A nurse aide with resident. (D) A member of form the resident and the An explanation must	usion of the resident and/or tive. ssment of the resident's s. resident's personal and in developing goals of care. Care Plans e care plan must be- 7 days after completion of assessment. interdisciplinary team, that imited to	F 28		

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				542 ALLRED MILL ROAD				
SURRY CO	OMMUNITY HEALTH AN	D REHAB CENTER		MOUNT AIRY, NC 27030				
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F 280	Continued From page		F 2	80				
	resident's care plan. (F) Other appropriate disciplines as determ or as requested by the (iii) Reviewed and reteam after each assessments. This REQUIREMENT by: Based on record reviewes, the facility Responsible Party (F) Plan meetings for 2 cand resident #5) revieparticipation in Care Findings included: 1. Resident #4 wa 01/18/2010 with cumincluded Diabetes and Quarterly Minimum Designation of Resident Record reviewed and was severely cognitive to the capacitation of Resident Record reviewed and resident Record reviewed Record Record reviewed Record Record Record reviewed Record	e staff or professionals in ined by the resident's needs e resident. Vised by the interdisciplinary sament, including both the quarterly review T is not met as evidenced liew and staff and family failed to invite the lar in Care of 3 residents (resident #4 lewed for notification of Plan meetings. Is admitted to the facility on culative diagnoses which do Chronic pain. The lata Set (MDS) dated the Resident #4 required 1 the Activities of Daily Living gnitively impaired. In which from April, 2016 until lated no documentation of RP lare plan meeting nor any participating in the meeting. In what also confirmed that this		F280 483.10 Right to Partice Planning Care-Revise CP 1. (a) Resident #4 RP invited attend care plan meeting on 05 Family attended care plan meeting on 05 Family attended care plan meeting on 05/15/2017. Family attend, however, MDS nurse in Resident #5's daughter and replan, medications, care cards, status on 05/02/2017. 2. Schedule created to ensure residents having the potential affected will have a care plan in 05/26/2017. Letters mailed to 05/10/2017. Care plans will be quarterly thereafter with the question of the meetings corrupon admission for new reside are scheduled quarterly thereafter with the components required to be in components required to be in the components.	d via mail 5/15/2017 eting and riewed. o care pla ly did not net with viewed cand over all to be meeting be families e schedul uarterly mpleted ents, and after.	an are all by on ed		
		ent #4 was attempted on 1. She did not was not		with F280. Random audits will completed on 5 residents (20 r	l be			

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				542 ALLRED MILL ROAD			
SURRY CO	OMMUNITY HEALTH AN	D REHAB CENTER		MOUNT AIRY, NC 27030			
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F 280	Continued From pag	e 10	F 28	30			
	about her significant			total) per hall by Director of Assistant Director of Nursing to ensure care plan meeting	g, or designee s are		
	Responsible Party of RP stated she never Care plan meetings. has been actively inv #4 since her placements.	cted with Resident # 4's n 4/29/2017 at 9:30 AM. The received any notification of The RP indicated that she volved in the care of Resident ent, but the staff would not re and treatment of Resident		scheduled, family invited, an occurred weekly x 4 weeks, x 3, or until no further issues 4. All results will be brought months, or until no further is	then monthly noted. to QAPI x 3		
	During an interview with the Social Worker on 4/29/2017 at 11 AM he revealed that he was aware that family member were not invited to the Care Plan meeting during the months of September 2016 through January 2017. He stated he was the assistant to the former Social Worker who left about two weeks ago.						
	Social Worker on 4/2 that she did not have of sending the reside the Care Plan meeting she "would leave a nand that there was n	nterview with the former 29/17 at 1 PM she revealed any written documentation ent's RP a letter to come to ng. The former SW indicated lotes in the resident rooms," o documentation kept during g, and there was no track of					
	4/29/2017 at 4:30 PM Social Worker had a inviting them to the ribut he was not award issue the letters to fa stated that his expec- would invite family (F	with the Administrator on M, he revealed that the facility letter to send to each family esident's care plan meeting, e the Social Worker did not amilies. The Administrator station was that the facility RP) and residents to all Care nat the notification be issued					

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F 280	O2/23/2016 with cum Anemia and Hyperte Minimum Data Set (I indicated that Reside assistance with Activ cognitively intact. Medical Record revie March 29, 2017 reve being invited to the o documentation of RF Medical Record revie family member was I Interview was condu Responsible Party of The RP stated she n of Care plan meeting had been in the care #5. Interview with Reside 4/29/2017 at 10:45 A question asked: how she had not been fee During an interview v 4/29/2017 at 11 AM I aware that family me Care Plan meeting d September 2016 thro stated he was the as Worker who left about	vas admitted to the facility on ulative which included nsion. The Quarterly MDS) dated March 2, 2017 ent #5 required 2 persons for ities of Daily Living and was ew from March 2016 until aled no documentation of RP are plan meeting nor any participating in the meeting. ew also confirmed that this Resident #5's RP. cted with Resident # 5's and 4/29/2017 at 10:30 AM. ever received any notification is. The RP indicated that she and treatment of Resident ent #5 was attempted on in the MS attempted on its week. Every the RP indicated that the ent #5 was attempted on in the RP indicated that eling well this week. with the Social Worker on the revealed that he was imber were not invited to the uring the months of bugh January 2017. He sistant to the former Social	F 2	280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345191	B. WING			C 04/29/2017	
NAME OF PR	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	29/2017
CURRY CO	MMIINITY UEALTH AND	DELIAD CENTED		54	12 ALLRED MILL ROAD		
SURRIC	OMMUNITY HEALTH AND	D REMAD CENTER		М	OUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 280	of sending the resident the Care Plan meeting she "would leave a not and that there was not the care plan meeting letters sent. During an interview wid/29/2017 at 4:30 PM that the facility Social to each family inviting plan meeting, but he worker did not issue Administrator stated if facility would invite fa all Care Plan meeting issued in a timely mat 483.25(d)(1)(2)(n)(1)-HAZARDS/SUPERVI (d) Accidents. The facility must ensure (1) The resident envir from accident hazards (2) Each resident record and assistance device (n) - Bed Rails. The fappropriate alternative bed rail. If a bed or simust ensure correct in maintenance of bed in to the following elements.	any written documentation nt's RP a letter to come to g. The former SW indicated oftes in the resident rooms," of documentation kept during g and there was no track of with the Administrator on I. The Administrator revealed Worker had a letter to send g them to the resident's care was not aware the Social the letters to families. The nis expectation was that the mily (RP) and residents to gs and that the notification be nner. (3) FREE OF ACCIDENT SION/DEVICES are that - conment remains as free s as is possible; and ever adequate supervision es to prevent accidents. facility must attempt to use es prior to installing a side or ide rail is used, the facility installation, use, and ails, including but not limited		280			5/29/17
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PRINTED: 06/07/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345191		B. WING _			04/29/2017	
	ROVIDER OR SUPPLIER	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	:	54/25/2511	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	F 323 Continued From page 13 from bed rails prior to installation.		F3	23			
	(2) Review the risks	and benefits of bed rails with ent representative and obtain					
	This REQUIREMEN by:	esident's size and weight. I is not met as evidenced		F323 □ 483.25 Free of Accide	ant.		
	interviews, the facility supervision when pro	on, record reviews, and staff y failed to provide adequate oviding ADL care (activities of		Hazards/Supervision/Devices			
	daily living) to an agitated and combative resident which resulted in a fall with a contusion and laceration to the head for 1 of 3 residents reviewed for accidents. (Resident #2)			Resident #2 was immediate emergency room for evaluation treatment via Emergency Medi Services (EMS). NA#12 was i questioned as to the education.	n and ical mmediately		
	Findings included:			received the previous week ab providing Activities of Daily Liv care. She stated she did have	out ing (ADL)		
	1/18/10 with diagnos			training, and she knew what she have done, but she didn't call f help. NA#12 was immediately re-educated on providing care combative or agitated resident was then suspended, escorted	ne should for extra to a . NA#12		
	The Fall Risk Assess indicated Resident #	ment dated 2/13/17 2 was a high risk for falls.		facility by SN#8 and SN#9, wh Manager on Duty. NA#12 did again in the facility and employ	o was also not work		
	(MDS) dated 2/13/17 short and long term r impaired decision-ma rejecting care; was fr bladder and always i MDS also indicated t extensive assistance	ige Minimum Data Set indicated Resident #2 had memory loss with moderately aking skills; had behavior of requently incontinent of incontinent of bowels. The he resident required of two staff for bed mobility; e the last assessment.		terminated. 2. NA#12's employment was to Direct care staff were re-educa 04/06/2017 regarding combative de-escalation and prevention. given additional re-education of ADL care for combative reside completed by 05/29/2017. 3. Random audits will be completed.	erminated. ated on veness, Staff will be on providing nts to be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		O MULTIPLE CONSTRUCTION SUILDING			(X3) DATE SURVEY COMPLETED C 04/29/2017	
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SURRY COMMUNITY HEA	LTH AN	ID REHAB CENTER		N	MOUNT AIRY, NC 27030			
PREFIX (EACH DE			MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE	
revealed fall mof Resident #2 The order also hospice care. The updated 0 resident's fall had a high rist of safety need lymphedema. (8/25/16)-staff resident when (12/8/16)-floor on one educated by included: "Rol the patient tow check: What is extra measure uncooperative Assistant (NA) in-service's attempt and the Resident #2 be during ADL cate floor mat hittin of an empty IV remained aller assessment be complained of noted with a be back of her he touched and contents."	Physical Phy	cian's Order dated 2/21/17 ere to be placed on each side due to her history of falls. aled the resident received lan dated 4/26/17 (after the 6/17) revealed the resident lls related to being unaware ory of falls and diagnosis of entions included: I not attempt to transport ras combative; I bedside; and, (4/26/17)-one th staff. ide Rail In-service" cility on 3/10/17-3/13/17 e patient in bed: Always roll rou. Before rolling the patient, atient's condition? Consider ey are confused, agitated or signature of Nursing vas included on this	F	323	Director of Nursing, Assistant Director Nursing, or designee on 12 residents week to ensure compliance with providable care for combative or agitated residents weekly x 4 weeks, then mon x 3, or until no further issues noted. 4. All results will be brought to QAPI x months, or until no further issues note	per ding thly		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345191	B. WING		C 04/29/2017		
	ROVIDER OR SUPPLIER	ID REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	1 04/23/2017		
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F 323	evaluation via emerge (EMT). The resident One-on-one education which stated "During becomes agitated or providing care should assistance in order to the review of the hosummary dated 3/19 with a contusion of hose consciousness with physical exam of the hemostatic (healing) scalp, normocephalist tomography) scan reacute intracranial abacute cervical fracture cervical fracture. During an interview Director of Nursing (NA#12 attended the included how to han combative. The DON NA#12 was involved Resident #2 was con ADL care causing the when she fell from the result, the NA was semployment with the next day. During an interview facility's District Director of the incident fall with a bump to the that when sent to the that when sent to the content of	vas sent to the hospital for gency medical transport (s family was notified.) On was provided to NA#12 (gresident care, if a resident of displays behaviors, the aide of step out of the room to get to protect resident safety." Ispital emergency room (h/17 diagnosed Resident #2 (ser head, no loss of minimal bleeding. The eresident's head revealed a abrasion of the posterior of the computerized evealed the resident had no normality; no evidence of the computerized evealed that on 3/10/17 (side Rail In-service which dele residents who were a revealed that on 3/19/17, in an incident in which mbative with the NA during the resident to hit her head the bed to the floor. As a	F 32	23			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	were negative, and facility the same day revealed: upon inversion to have followed procare for Resident #2 Director of Clinical \$03/19/17 there shown members providing was combative. When the most recent instocombative reside know what I should result of the NA's rewith the facility was combativeness, dewas provided on 4/6 The interview on 4/2 SN#9 was the Manathe accident occurre informed by one of the provided by NA#12. SN#8. Upon arrival indicated she obserfloor on her back, all but had a moderate back of the resident assessed the resident the resident became were able to get the transported her to the she was given a full SN#8. The DON teleinstructed SN#8 and re-education on where	ge 16 ges, the CT scan and x-rays the resident returned to the y. The District Director also stigation, NA#12 was found to rotocol when providing ADL 2 on 03/10/17. The District Gervices stated that on alld have been two staff ADL care for Resident #2 who en NA#12 was reminded of fervice on providing ADL care ants, NA#12's reply was "yes, I have done, I just didn't". As a sponse, NA#12's employment terminated. Re-education on escalation and prevention 6/17 to all direct care staff. 27/17 at 4:48 pm revealed ager on Duty on 3/19/17 when ed. SN#9 stated that she was the staff nurses that Resident room during incontinent care EMT had been called by to the resident's room, SN#9 ved the resident's room, SN#9 ved the resident lying on the left, not drowsy or lethargic, amount of bleeding from the 's head. The hall nurse ent and the two hall NAs nt's vital signs. EMT arrived, a agitated, but the paramedics are sident on the stretcher and the hospital. SN#9 revealed report of the incident from ephoned the facility and d SN#9 to provide one-on-one en a resident becomes at the nursing assistant was to	F 32	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ID REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	1 04/20/2017		
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F 323	request assistance in nursing assistant. Eat the time of the acreceived the re-educacknowledgement. Stelephoned the facilishe was suspended escorted NA#12 out On 4/28/17 at 10:48 to contact NA#12 remessage indicating longer in service. Thattempted phone nuprovided to the facilisher were up (locate Resident #2 was as position. The head capproximately 80 derails were up (locate Floor mats were on was in the standard was drawn due to twee providing care During an interview Hospice NA#13 revenospice NA provided five days each week She also revealed to required when turning resident. Hospice Namon-ambulatory was never combative.	s safety, leave the room and rom a nurse or another oth NAs assigned on the hall cident, including NA #12, cation and signed the SN#9 indicated the DON ty again and informed NA#12 at that time. SN#9 and SN#8 of the facility. am, unsuccessful attempts sulted in a service provider's the phone number was note DON revealed the mber was the only one ty by NA#12. on on 4/28/17 at 12:53 pm, eep in the bed in a fetal of the bed was up at the grees and both quarter side dowards middle of bed). each side of the bed which position. The privacy curtain to hospice nursing assistants to the resident in bed B. on 4/28/17 at 1:16 pm, ealed she and one other did ADL care to Resident #2, at at approximately 2:00 pm. we hospice staff were and repositioning the la#13 stated that the resident to She indicated the resident eduring care but would enever her legs were	F 323				

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	I	04/29/2017		
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F 323	During an interview indicated Resident required two staff for totally incontinent or stated that the resident would com whenever her legs would inform the nurgiven pain medication resident had areas to lymphedema. During a telephone pm, SN#8 revealed of Resident #2's acc stated that NA#12 rhad fallen from her entering the resident lying on her bed A and B. The resident lying on her bed A and B. The resident shad pressure was applied to the resident's head pressure was applied Neurological checks assessment and consigns were taken are noted the IV pole be and B with one of the outward (approximates resident was lifting by the resident was	on 4/28/17 at 1:36 pm, NA#1 #2 was mostly bedbound, or all of her ADL care and was f bowel and bladder. NA#1 Hent was turned and hour. She revealed the plain of leg pain and cry out were moved or touched. NA#1 rse and the resident would be on. NA#1 stated that the on both of her lower legs due interview on 4/28/17 at 2:21 she was on duty at the time cident on 03/19/17. SN#8 hotified her that Resident#2 bed to the floor. Upon ht's room, SN#8 observed the or back on the floor between resident was conscious. SN#8 but moving the resident from hoted an assessment of the herved bleeding at the back of (right above her neck),	F 3	23				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345191		l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 353 SS=E	hospital emergency following Resident # reported to her that room to provide incoinformed SN#8 that her left side (toward NA#12; the resident her left hand while sbackwards attempting resident's legs slid to and hit her head on 483.35(a)(1)-(4) SU	resident was sent to the room. SN#8 stated that t2's fall on 03/19/17, NA #12 she went into the resident's ontinent care. NA#12 she turned Resident#2 onto is the window) away from was holding the side rail with winging her right arm ing to hit NA#12 when the of the floor around the side rail the base of the IV pole. FFICIENT 24-HR NURSING PLANS	F 3.		5/29/17
	the appropriate comprovide nursing and resident safety and a practicable physical well-being of each resident assessment and considering the diagnoses of the factor accordance with the at §483.70(e). [As linked to Facility be implemented beging (Phase 2)] (a) Sufficient Staff. (a)(1) The facility musufficient numbers of personnel on a 24	ve sufficient nursing staff with petencies and skills sets to related services to assure attain or maintain the highest mental, and psychosocial esident, as determined by ts and individual plans of care number, acuity and cility's resident population in facility assessment required Assessment, §483.70(e), will ginning November 28, 2017 Lest provide services by a feach of the following types be sidents in accordance with			

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		345191 B. WI				C 04/29/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		04/29/2017	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 353	(i) Except when waive this section, licensed (ii) Other nursing per limited to nurse aided (a)(2) Except when we this section, the facil nurse to serve as a conduty. (a)(3) The facility munurses have the spent sets necessary to call identified through residentified through residentifi	red under paragraph (e) of a nurses; and resonnel, including but not s. vaived under paragraph (e) of ity must designate a licensed charge nurse on each tour of lest ensure that licensed cific competencies and skill are for residents' needs, as sident assessments, and	F 3	DEFICIENCY)			
	by: Based on observation interviews the facility staffing to provide sustactivities of daily living residents and failed control policy on 2 of referenced to tags Findings included: 1. F323 Based on obtained staff interviews, adequate supervision (activities of daily living combative resident with staff interviews).	ons, record reviews and staff railed to provide sufficient upervision when assisting with ng (ADL) care for 1 of 3 to follow their infection f 4 halls. This tag is cross		F353 483.35 Sufficient 24 Staff per Care Plans 1. (a) Resident #2 was imme to emergency room for evalute treatment via Emergency Me Services (EMS). NA#12 was questioned as to the education received the previous week a providing Activities of Daily L care. She stated she did have training, and she knew what have done, but she didn't cal help. NA#12 was immediate re-educated on providing car	ediately sent eation and edical s immediately on she had about iving (ADL) we the she should Il for extra		

STREET ADDRESS, CITY, STATE, ZP CODE 542 ALL RED MILL ROAD STREET ADDRESS, CITY, STATE, ZP CODE 542 ALL RED MILL ROAD STATE ALL RED MILL ROAD STATE ALL RED MILL ROAD MOUNT AIRY, NC. 27030	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED		
SURRY COMMUNITY HEALTH AND REHAB CENTER MUNITATIRY, V2 2739. FRETIX TAG. FRETIX TAG. Continued From page 21 2. F441 Based on observations, record reviews and staff interview the facility failed to follow their infection Control policy entitled "Contact Isolation" for residents on 2 of 4 halls (200 and 300 halls). An interview was completed with Nurse Aide #2 (NA) on 4/27/17 at 1/30 PM. She stated because there are only 2 nurses' aides on each hall that sometimes residents had to wait a little longer to receive care. An interview was completed with the Director of Nursing (DON) on 4/27/17 at 3.09 PM. She reported there had been issues with staffing and that she had pulled administrative nursing staff to work when staffing is short. She stated the facility social worker had left recently and "took a lot of staff with her." An interview was completed with Resident #18 on 4/29/17 at 9.37 AM. She stated the issues with staffing were discussed in Resident Council meetings, including that there was not enough nursing staff on the halls. Resident #18 reported that the facility and not specifically addressed ways they were resolving the issues the Resident Council brought up in the meetings. An interview was completed with the Activities Director on 4/29/17 at 10.21 AM. She stated she has worked the hall at times (she is also a certified nursing assistant), most recently 4/28/17 from 3 PNA-6 PM. She reported the DON had asked. "Can you just go down" if Aflat for a little bit?" She stated thu source if the wasted to work the bit?" She stated nursing administration had asked resometimes if she wanted to work the			345191	B. WING _	B. WING			I - I	
SURRY COMMUNITY HEALTH AND REHAB CENTER MOUNT AIRY, NC 27030	NAME OF PE	ROVIDER OR SUPPLIER			ST	REET ADDRESS CITY STATE ZIP CODE	1 04/	29/2017	
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F 353 Continued From page 21 residents reviewed for accidents (Resident #2). 2. F441 Based on observations, record reviews and staff interviews the facility failed to follow their infection Control policy entitled "Contact Isolation" for residents or 20 d halls (200 and 300 halls). An interview was completed with Nurse Aide #2 (NA) on 4/27/17 at 1:30 PM. She stated because there are only 2 nurses' aides on each hall that sometimes residents had to wait a little longer to receive care. An interview was completed with the Director of Nursing (DON) on 4/27/17 at 3:09 PM. She reported there had been issues with staffing and that she had pulled administrative rursing staff to work when staffing is short. She stated the facility social worker had left recently and Took a lot of staff with her.* An interview was completed with Resident #18 on 4/29/17 at 19:37 AM. She stated the issues with staffing were discussed in Resident Council meetings, including that there was not enough nursing staff on the halls. Resident #18 reported that the facility had not specifically addressed ways they were resolving the issues the Resident Council meetings, including that there was not enough nursing staff on the halls. Resident #18 reported that the facility had not specifically addressed ways they were resolving the issues the Resident Council meetings, including that there was not enough nursing staff on the halls. Resident #18 reported that the facility had not specifically addressed ways they were resolving the issues the Resident Council meetings, including that there was not enough nursing assistant), most recently 4/28/17 from 3 PM-6 PM. She reported the DN had asked. "Can you just go down "A hall for a little bit?" She stated nursing administration had asked her sometimes if she wanted to work the	SURRY CO	OMMUNITY HEALTH A	ND REHAB CENTER						
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 353 Continued From page 21 residents reviewed for accidents (Resident #2). 2. F441 Based on observations, record reviews and staff interviews the facility failed to follow their infection Control policy entited *Contact Isolation* for residents on 2 of 4 halls (200 and 300 halls). An interview was completed with Nurse Aide #2 (NA) on 4/27/17 at 1:30 PM. She stated because there are only 2 nurses' aides on each hall that sometimes residents had to wait a little longer to receive care. An interview was completed with the Director of Nursing (DON) on 4/27/17 at 3:09 PM. She reported there had been issues with staffing and that she had pulled administrative nursing staff to work when staffing is short. She stated the facility social worker had left recently and "took a lot of staff with her." An interview was completed with Resident #18 on 4/29/17 at 9:37 AM. She stated the issues with staffing were discussed in Resident Council meetings, including that there was not enough nursing staff on the halls. Resident #18 reported that the facility had not specifically addressed ways they were resolving the issues the Resident Council meetings, including that there was not enough nursing staff or the halls. Resident #18 reported that the facility had not specifically addressed ways they were resolving the issues the Resident Council meetings, including that there was not enough nursing staff or the halls. Resident #18 reported that the facility had not specifically addressed ways they were resolving the issues the Resident Council meetings. No providence that the facility had not specifically addressed ways they were resolving the issues the Resident Council meetings. No providence that the facility had not specifically addressed ways they were resolving the issues the Resident Council meetings. No providence that the facility had not specifically addressed ways they were resolving the issues the Resident Council meetings. No providence that the facility had no					IVI	CONTAIRT, NC 27030			
residents reviewed for accidents (Resident #2). 2. F441 Based on observations, record reviews and staff interviews the facility failed to follow their infection Control policy entitled "Contact Isolation" for residents on 2 of 4 halls (200 and 300 halls). An interview was completed with Nurse Aide #2 (NA) on 4/27/17 at 1:30 PM. She stated because there are only 2 nurses' aides on each hall that sometimes residents had to wait a little longer to receive care. An interview was completed with the Director of Nursing (DON) on 4/27/17 at 3:09 PM. She reported there had been issues with staffing and that she had pulled administrative nursing staff to work when staffing is short. She stated the facility social worker had left recently and "took a lot of staff with her." An interview was completed with Resident #18 on 4/29/17 at 9:37 AM. She stated the issues with staffing were discussed in Resident Council meetings, including that there was not enough nursing staff on the halls. Resident #18 reported that the facility had not specifically addressed ways they were resolving the issues the Resident Council brought up in the meetings. An interview was completed with the Activities Director of Al29/17 at 10:21 AM. She stated the issues with staffing agencies, in the process of obtaining contract with another staffing agency to ensure sufficient staffing agency to	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
as then suspended, escorted out of facility by SN#8 and SN#9, who was also Manager on Duty. NA#12 did not work again in the facility and employment was terminated. Currently have contract with two staffing agencies, in the process of obtaining contracts with another staffing agency to ensure sufficient was terminated. Currently have contract with two staffing agency to ensure sufficient staffing. Facility administrator created a wage compensation package for review. (b) Staff were immediately re-educated on Contact Isolation and Personal Protective Equipment (PPE). Currently have contract with two staffing agencies, in the process of obtaining contracts with another staffing. Facility administrator created a wage compensation package for review. (b) Staff were immediately re-educated on Contact Isolation and Personal Protective Equipment (PPE). Currently have contract with two staffing agencies, in the process of obtaining contract with another staffing agency to ensure sufficient staffing. Facility administrator created a wage compensation package for review. 2 (a) NA#12's employment was terminated. Currently have contract with two staffing agencies in the process of obtaining contract with another staffing agencies in the process of obtaining package for review. 2 (a) NA#12's employment was terminated. Direct care staffing. Facility administrator created a wage compensation package for review. 2 (a) NA#12's employment was terminated. Direct care staffing agencies, in the process of obtaining contract with nother staffing agencies, in the process of obtaining contract with nother staffing agencies, in the process of obtaining contract with nother staffing agencies, in the process of obtaining contract with nother staffing agencies, in the process of obtaining contract with nother staffing agencies, in the process of obtaining contract with nother staffing agencies, in the process of obtaining contract with nother staffing agencies, in the process of obtaining agencies, in the process of obtaining agencies	F 353	Continued From pa	ge 21	F3	353				
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agency to ensure sufficient staffing. An interview was completed with the Activities Director on 4/29/17 at 10:21 AM. She stated she has worked the hall at times (she is also a certified nursing assistant), most recently 4/28/17 from 3 PM-6 PM. She reported the DON had asked, "can you just go down 'A' hall for a little bit?" She stated nursing administration had asked her sometimes if she wanted to work the agency to ensure sufficient staffing. Facility administrator created a wage compensation package for review. (b) Nursing, housekeeping, therapy and office staff will be retrained on Hand Hygiene, Hand washing, Contact Isolation and PPE by 05/29/2017. Currently have contract with two staffing agencies, in the process of obtaining a contract with			•						
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has worked the hall at times (she is also a certified nursing assistant), most recently 4/28/17 from 3 PM-6 PM. She reported the DON had asked, "can you just go down 'A' hall for a little bit?" She stated nursing administration had asked her sometimes if she wanted to work the (b) Nursing, housekeeping, therapy and office staff will be retrained on Hand Hygiene, Hand washing, Contact Isolation and PPE by 05/29/2017. Currently have contract with two staffing agencies, in the process of obtaining a contract with			· ·			-			
certified nursing assistant), most recently 4/28/17 from 3 PM-6 PM. She reported the DON had asked, "can you just go down 'A' hall for a little bit?" She stated nursing administration had asked her sometimes if she wanted to work the office staff will be retrained on Hand Hygiene, Hand washing, Contact Isolation and PPE by 05/29/2017. Currently have contract with two staffing agencies, in the process of obtaining a contract with							d		
from 3 PM-6 PM. She reported the DON had asked, "can you just go down 'A' hall for a little bit?" She stated nursing administration had asked her sometimes if she wanted to work the Hygiene, Hand washing, Contact Isolation and PPE by 05/29/2017. Currently have contract with two staffing agencies, in the process of obtaining a contract with			•				-		
asked, "can you just go down 'A' hall for a little bit?" She stated nursing administration had asked her sometimes if she wanted to work the asked. "can you just go down 'A' hall for a little and PPE by 05/29/2017. Currently have contract with two staffing agencies, in the process of obtaining a contract with							ion		
bit?" She stated nursing administration had contract with two staffing agencies, in the asked her sometimes if she wanted to work the process of obtaining a contract with									
asked her sometimes if she wanted to work the process of obtaining a contract with						•			
			•						
weekend. The Activities Director said that on a another staffing agency to ensure						another staffing agency to ensure			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345191	B. WING _	B. WING		C 04/29/2017	
NAME OF PR	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	14/23/2017	
				542 ALLRED MILL ROAD			
SURRY CO	SURRY COMMUNITY HEALTH AND REHAB CENTER			MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 353	schedule to accomme asked to help with. An interview was con 4/29/17 at 10:39 AM. used the Activities Did 4/28/17 because "the schedule. She stated normal pool of people (ward clerk/medical reactivities director), whas is tants. A second interview won 4/29/17 at 3:51 Phrecently lost some staworked the floor with is because we don't from." Both the DON Nursing (ADON) world 4/29/17 because one there was no one available.	and to rearrange the activities obtate other duties she was expected with the DON on She confirmed she had rector to fill in as a NA on the was an open spot" on the difference was an open spot on the difference was completed with the DON who was completed with the DON who was completed with the DON who was completed with the facility had aff and that office staff had in the last two weeks. "This have a pool of people to ask and Assistant Director of ked a hall from 3-7 AM on nurse called in sick and will able to cover the other hall. The difference was that there of the building to provide	F3	sufficient staffing. Facility administrated a wage compensation parfor review. 3. (a) Random audits will be computed or of Nursing, Assistant Director of Nursing, Assistant Director of Nursing, or designee on 12 resided week to ensure compliance with participation of ADL care for combative or agitate residents weekly x 4 weeks, then x 3, or until no further issues note Schedule will be reviewed by Director of Nursing or Assistant Director of Nursing or Assistant Director of Nursing in place daily x 4 then weekly x 4 weeks, then mon or until no further issues noted. (b) Director of Nursing, Assistant of Nursing or designee will compliant to make the monthly x Schedule will be reviewed by Director of Nursing or Assistant Director of Nursing or Assis	ckage pleted by ector of ents per providing ed monthly d. ector of ursing 4 weeks, thly x 3, Director ete pliance ector of ursing 4 weeks, thly x 3, API x 3		
F 431 SS=E	drugs and biologicals them under an agree §483.70(g) of this par unlicensed personnel law permits, but only	GS & BIOLOGICALS ride routine and emergency to its residents, or obtain ment described in rt. The facility may permit I to administer drugs if State under the general	F 4			5/29/17	
	supervision of a licen	300 Hul36.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345191		· ,	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345191	B. WING		C 04/29/2017		
	ROVIDER OR SUPPLIER	ID REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	1 0 11 20 12		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION		
F 431	Continued From pag	ge 23	F 43	1			
	that assure the accurdispensing, and admitiologicals) to meet (b) Service Consultatemploy or obtain the pharmacist who (2) Establishes a systisposition of all condetail to enable an a (3) Determines that that an account of all maintained and periodical professional principle appropriate accessor instructions, and the applicable. (h) Storage of Drugs (1) In accordance with facility must store locked compartment controls, and permit have access to the king (2) The facility must permanently affixed controlled drugs listed	ices (including procedures rate acquiring, receiving, ninistering of all drugs and the needs of each resident. Ition. The facility must exercises of a licensed stem of records of receipt and trolled drugs in sufficient ccurate reconciliation; and drug records are in order and I controlled drugs is odically reconciled. Is and Biologicals. It is used in the facility must be be with currently accepted es, and include the rry and cautionary expiration date when and Biologicals. It is the State and Federal laws, eall drugs and biologicals in sunder proper temperature only authorized personnel to					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345191	B. WING		C 04/29/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/29/2017	
				542 ALLRED MILL ROAD		
SURRY CO	OMMUNITY HEALTH AN	D REHAB CENTER		MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 431	Continued From pag	e 24	F 43	11		
	abuse, except when package drug distribution quantity stored is minder the readily detected. This REQUIREMENT by: Based on observation interviews the facility insulin pen, 1 Lantus	and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can T is not met as evidenced ons, record reviews, and staff failed to remove 1 Humalog pen, 1 Novolog Mix 70/30		F431 □ 483.45 Drug Records, Label/Store Drugs & Biologicals		
	pen that were not lab for use in 3 of 4 med and 300 halls. Staff	pens and 1 Levemir insulin beled or dated when opened ications carts on 100, 200 also failed to remove 4		(a) Insulin pen for Resident #1 was immediately removed from medication cart and discarded. Facility policy entill Insulin Storage Recommendation was	n tled	
	and not labeled avail medication carts on carts and also failed	locaine that were opened able for use in 2 of 4 100 and 300 hall medication to remove 1 vial of sterile om 1 of 4 carts on 300hall.		placed in a notebook on the medicatic cart as a reference. Re-education on expiration date of medications comple for all nurses on 04/27/2017 during first and second shift.	eted	
	Findings included:			(b)Insulin pen for Resident #14 was immediately removed from medication cart and discarded. Facility policy enti		
	Storage in the Facilit Section 4.1 dated Ma medications or packa solutions, multiple do ophthalmics, nitrogly testing solutions and an expiration date to inspotency. It further state seal of a manufacture initially broken, the coal further review of the that the nurse shall p	y policy entitled Medication y, Storage of Medications ay 2012 indicated that certain age types, such as IV use injectable vials, cerin tablets, blood sugar strips, once opened, require norter than the manufactures ure medication purity and ates that when the original er's container or vial is container or vial will be dated. e facility policy also indicates olace a "date opened" sticker and enter the date opened and		Insulin Storage Recommendation was placed in a notebook on the medication cart as a reference. Re-education on expiration date of medications comple for all nurses on 04/27/2017 during first and second shift. (c)Insulin pen for Resident #15 was immediately removed from medication cart and discarded. Facility policy entill Insulin Storage Recommendation was placed in a notebook on the medication cart as a reference. Re-education on expiration date of medications comple for all nurses on 04/27/2017 during first and second shift.	eted st tled son	
	the new date of expir	ration (NOTE: the best and both a "date opened" and		The seven insulin pens in question we removed immediately from the medical		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25	_			c l	
		345191	B. WING _				29/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	23/2017	
					42 ALLRED MILL ROAD			
SURRY C	OMMUNITY HEALTH	AND REHAB CENTER			OUNT AIRY, NC 27030			
	0,111,112	A OTATEMENT OF DEFICIENCIES			<u>, </u>			
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 431	Continued From p	age 25	F4	431				
	"expiration notation	n line). The expiration date of			cart and discarded. The four multidose	!		
		er will be [30] days unless the			vials of Lidocaine in question were			
		mmends another date or			removed immediately from the medicat	ion		
	regulations/guideli	nes requires different dating.			carts and discarded. The one vial of			
		es that the nurse will check the			sterile water for injection was removed			
	expiration date or	each medication before			immediately from the medication cart a	nd		
	administering it, th	at no expired medication will be			discarded. Nurses that were present			
	administered to a	resident, that all expired			were immediately re-educated on med			
		removed from the active supply			storage and labeling meds with date wh	nen		
		ne facility, regardless of amount			opened.			
	_	medication will be destroyed in			(d) Insulin pen for Resident #16 was			
		The policy also indicates that			immediately removed from medication			
	_	nould consult with the			cart and discarded. Facility policy entitle	ea		
	to medication expi	acist for any questions related			Insulin Storage Recommendation was placed in a notebook on the medication			
		ility policy entitled Insulin			cart as a reference. Re-education on	ı		
		endation with a revision date of			expiration date of medications complete	-d		
	_	14 indicates that opened			for all nurses on 04/27/2017 during first			
		and Novolog pens at room			and second shift.	•		
	_	be discarded after 28 days,			(e) Insulin pen for Resident #17 was			
	· ·	pens are to be discarded after			immediately removed from medication			
	14 days and Level	mir pens are to be discarded			cart and discarded. Facility policy entitle	ed		
	after 42 days.				Insulin Storage Recommendation was			
	A review of the fac	ility policy entitled Expiration			placed in a notebook on the medication	1		
		at Lidocaine (multidose) vials			cart as a reference. Re-education on			
		nperature are to be discarded			expiration date of medications complete			
	30 days after oper				for all nurses on 04/27/2017 during first	t		
		ility policy entitled Recommend			and second shift.			
		on Storage Parameters (based			(f) (1) Multidose vials of Lidocaine were	;		
	_	uidance) Injectable			immediately removed from medication			
		ites that Bacteriostatic (sterile)			cart and discarded. Re-education on	- d		
	I	should be dated when opened			expiration date of medications complete			
		days after first use. s admitted to the facility on			for all nurses on 04/27/2017 during first and second shift.	L		
		agnoses included diabetes			(f) (2) Multidose vial of Sterile Water for	-		
		agnoses included diabetes nysician's order dated			Injection was immediately removed from			
		ed that Resident #1 receive			medication cart and discarded.			
		100u/ml via Pen, inject 20 units			Re-education on expiration date of			
	_	Q) before meals related to DM			medications completed for all nurses or	า		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
				_		(С
		345191	B. WING			04/	29/2017
	ROVIDER OR SUPPLIER	D REHAB CENTER	·	54	TREET ADDRESS, CITY, STATE, ZIP CODE 12 ALLRED MILL ROAD IOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	sliding scale dose on On 04/26/2017 at 4:4 pen was observed or ready for use and wa place and undated. On 04/26/2017 at 4:4 conducted with Nurse had used the Novolo med cart for Residen When asked what the Flex Pen was she state expiration date on the did not know when Nother refrigerator and of dated label should be indicated the date op she did not know when was unable to determ pen had expired prior insulin on 04/26/2017 not look for the label injectable medication the cart and discarded immediately removed from the 200hall med On 04/26/2017 at 5:0 Medication Administrative aled that Reside units on 04/27/2017 orders as indicated boon the MAR. On 04/26/2017 at 5:2 conducted with the A (ADON) who stated the nursing staff would have resident #1 where	x Pen Solution to cover the dered. 5PM Resident #1's Novolog in the 200hall medication cart is opened, had no sticker in 5PM an interview was at #1. She stated that she is given located on 200 hall it #1 for the morning dose. It was expiration date for Novolog atted the manufacturer at pen and confirmed that she ovolog expired once out of opened. She stated that at it is novolog without an opened date she inne if Resident #1's Novolog in the radministering the pen and that it is should be removed from the did when it is expired. She is the undated Novolog pen dication cart and discarded it.	F	431	04/27/2017 during first and second shift (g) (1) Multidose vials of Lidocaine wer immediately removed from medication cart and discarded. Re-education on expiration date of medications complete for all nurses on 04/27/2017 during first and second shift. (g) (2) Insulin pen for unknown residenthat was undated was immediately removed from medication cart and discarded. Facility policy entitled Insulistorage Recommendation was placed a notebook on the medication cart as a reference. Re-education on expiration date of medications completed for all nurses on 04/27/2017 during first and second shift. 2. 100% audit of all medication carts we checked to ensure all opened medication that require a date were dated. All nurs will be re-educated on labeling meds when opened. 3. Director of Nursing, Assistant Director of Nursing, Staff Development Manage MDS nurses will perform daily cart aud daily, 5x/week x 4 weeks, then weekly months. Director of Nursing, Assistant Director of Nursing, or Staff Development Manager to do random weekly checks thereafter to ensure compliance. 4. All results will be brought to QAPI x 3 months, or until no further issues noted.	ed t t t in in ere ons ses or er, its x 3 ent	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345191	B. WING			C)4/29/2017	
	ROVIDER OR SUPPLIER	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		14,23,2011	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
F 431	checked that Residdated when opened Novolog pen to Res 04/26/2017 and that identified that Residdated when opened discarded prior to a an opened date the when the Novolog paction plan identifie policy entitled Insuli with a revision date of all 4 medication on the book located in reference. On 04/27/2017 at 2 conducted with the who stated that her nursing staff would per facility policy an administered medic known expiration daring first and second medication cart che DON, ADON, Staff and Minimum Data Monday night on the dates of medication and dating when op procedure Sunday we have all medication order. On 04/27/2017 at 2 Clinical Pharmacist his expectation is than dated immediation.	er facility protocol, would have ent #1's Novolog pen was I prior to administering the sident #1 the morning of to the nursing staff would have lent #1's Novolog pen was not I and would have to be deministration because without are was no way to determine the had expired. Her prompt do placing a copy of the facility in Storage Recommendation of September 29, 2014 on top the sarts and in their information is side of their cart as a side of their cart as a side of the sarts and in the sarts and i	F 43				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NG		1 ,	С
		345191	B. WING			1	29/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	•	
CLIDDY C	OMMINITY HEALTH	AND BEHAD CENTED		542 A	ALLRED MILL ROAD		
SURKTO	OMMUNITY HEALTH A	AND REHAB CENTER		MOU	INT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 431	information can be On 04/29/2017 at Administrator was his expectation that date all necessary policy. He confirme had initiated reedu regards to expiration the mediation carts education had take working first and so would continue untreeducated. He staprior to administeri should have check labeled appropriate facility protocol. 2. Resident #14 would only to administeri should have check labeled appropriate facility protocol. 2. Resident #14 would only to administeri should have check labeled appropriate facility protocol. 2. Resident #14 receivia Pen before mescale dose ordered dated 04/21/2017 in receive Lantus Sol 100 units/ml, inject On 04/26/2017 at a Novolog and Lantu 200 hall medication opened and undated On 04/26/2017 at a conducted with Nuhad used the Lantu cart for Resident # stated that she had Novolog pen on 04/20/2019 on 04/20/20	all be discarded and this found in the facility policy. 11:30am an interview with the conducted and stated that it is it nurses administer, label and medication when opened per ed that the DON and ADON cation to the nursing staff in on dates of open medication on within the facility and that this en place with the nursing staff econd shifts on 04/26/2017 and ill all nursing staff had been ated that his expectation is that ing insulin to Resident #1, staff that the insulin had been ely with an opened date as per as admitted to the facility on agnoses included DM. A ated 04/21/2017 indicated that we Novolog Solution 100u/ml als SQ to cover the sliding d. Another physician's order indicated that Resident #14 oStar Solution Pen 5 units SQ one time a day. 4:45PM Resident #14's is pens were observed on the cart ready for use and was	F	431			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING				C 29/2017	
NAME OF PI	ROVIDER OR SUPPLIER	0.0.0.			STREET ADDRESS, CITY, STATE, ZIP CODE	04/	29/2017	
					542 ALLRED MILL ROAD			
SURRY CO	OMMUNITY HEALTH	AND REHAB CENTER			MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 431	Continued From p	age 29	F4	431				
	were, she stated s	he did not know the date and						
		e did not know when Lantus nor						
	Novolog expired o	nce opened and were out of						
	• .	ne confirmed that a dated label						
	_	ted the date opened. She						
		e did not know when Resident						
		Novolog pens were opened and						
	without an opened	I date she was unable to						
	determine if Resid	ent #14's Lantus and Novolog						
	pens had expired	prior to her administering the						
	Lantus on 04/26/2	017. She confirmed that she						
	did not look for the	e label or the opened date and						
	that injectable med	dication should be removed						
	from the cart and	discarded when it is expired.						
	She immediately r	emoved the undated Lantus						
	and Novolog pens	from the 200hall medication						
	cart and discarded	I them.						
	On 04/26/2017 at	5:00PM a review of the MAR						
		dent #14 received Lantus 5						
		7 at 9:00AM per physician's						
		d by Nurse #1's documentation						
	on the MAR.							
		5:20PM an interview was						
		e ADON who stated that her						
	-	ne nursing staff would have						
		and Novolog pens for Resident						
		pened as per facility policy. She						
		pectation was that the nursing						
		otocol, would have checked						
		s Lantus pen was dated when						
		ministering the Lantus to						
		morning of 04/26/2017 and that						
	_	d have identified that Resident						
		Novolog pens were not dated						
	-	would have to be discarded						
	·	tion because without a correctly						
	-	ate there was no way to						
		ne Lantus and Novolog pens						
	nad expired. He p	rompt action plan was to place						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 04/29/2017	
	ROVIDER OR SUPPLIER	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		14/23/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 431	Recommendation we September 29, 201 carts and in their initiated of their cart at On 04/27/2017 at 2 conducted with the expectation was that labeled the insuling would have not admiresident without at k stated that they initiously by DON, ADO and every Monday expiration dates of multidose vials and match back proceds shift to ensure we houilding per physici On 04/27/2017 at 2 Clinical Pharmacist his expectation is thand dated immediat refrigeration and kn long until they shou information can be On 04/29/2017 at 1 Administrator was on 04/29/2017 at 1 Administra	r policy entitled Insulin Storage rith a revision date of 4 on top of all 4 medication formation notebook located is a reference. OPM an interview was DON who stated that her at the nursing staff would have been per facility policy and ninistered medication to a nown expiration date. She ated reeducation of all staff on irst and second shift that tion cart checks will be done N, Staff SDM and MDS nurse night on third shift checking for medications, insulin and dating when opened and ure Sunday nights on third ave all medications in the	F 4	31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 04/29/2017
	ROVIDER OR SUPPLIER	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP OF STATE AND STATE, ZIP OF STATE AND STATE	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULI		
F 431	that prior to administ staff should have che been labeled approp as per facility protoco 3. Resident #15 was 08/17/2015 and diag physician's order dat Resident #15 receive via pen SQ before m On 04/26/2017 at 4:4 Humalog pen was obmedication cart reading and undated. On 04/26/2017 at 4:4 conducted with Nurshad used the Humalomed cart for Resident and evening doses. Vexpiration date for Hishe did not know when Hopened and out of the that a completed label date opened and that Resident #15's Humastated that without an unable to determine pen had expired prio Humalog on 04/26/20 did not look for the lathat injectable medic from the cart and dis She immediately rempen from the 200hall discarded it.	ified that his expectation is ering insulin to Resident #14, ecked that the insulin had riately with an opened date ol. admitted to the facility on noses included DM. A ed 10/13/2016 indicated that a Humalog Solution 5 units eals. ISPM Resident #15's eserved on the 200hall by for use and was opened ISPM an interview was er #1. She stated that she eg pen located on 200 hall at #15 for the morning, lunch When asked what the eumalog Pens was, she stated and that confirmed that she el umalog expired once er erfrigerator. She stated el would have indicated the tashe did not know when alog pen was opened. She in opened date she was if Resident #15's Humalog if Resid	F	431		
		nt #15 received Humalog 5 at 7:30AM, 11:30AM and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		345191	B. WING			C	
	ROVIDER OR SUPPLIER	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIF 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		4/29/2017	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 431	Nurse #1's docum On 04/26/2017 at conducted with the expectation was to dated the Humalow was opened as perference on 04/27/2017 at conducted with the expectation was desident #15's Howhen opened and prior to administration opened date there the Humalog logication plan was to policy entitled Insignification of all 4 medication notebook located reference. On 04/27/2017 at conducted with the expectation was to labeled the insuling would have not accommodate the expectation without a stated that they in 04/27/2017 during announced medicidally by DON, AD and every Monda expiration dates of multidose vials ar match back process.	cian's orders as indicated by nentation on the MAR. 5:20PM an interview was e ADON who stated that her he nursing staff would have g pen for Resident #15 when it er facility policy. She stated that as that the nursing staff, per ould have checked that unalog pen was dated when dministering the Humalog to be times the day of 04/26/2017 staff would have identified that unalog log pen was not dated a would have to be discarded ation because without an evas no way to determine when been had expired. Her prompt of place a copy of the facility ulin Storage Recommendation the of September 29, 2014 on top in carts and in their information inside of their cart as a 2:00PM an interview was be DON who stated that her hat the nursing staff would have in pens per facility policy and dministered medication to a known expiration date. She intitated reeducation of all staff on the grief of the staff on the control of the staff on the	F	431			

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345191	B. WING		C 04/20/2047		
NAME OF P	ROVIDER OR SUPPLIER	040101	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		4/29/2017	
TO WILL OF T	NOVIDEN ON OUT FIEN			542 ALLRED MILL ROAD	, <u> </u>		
SURRY C	OMMUNITY HEALTH AN	ND REHAB CENTER		MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 431	Continued From pag	ge 33	F 4	31			
	building per physicial On 04/27/2017 at 2: Clinical Pharmacists his expectation is the and dated immediate refrigeration and knot long until they shoul information can be for 004/29/2017 at 11 Administrator was consisted and interest of the mediation carts or regards to expiration the mediation carts or reeducation had take working first and see would continue until reeducated. He specthat prior to administ staff should have chabeled appropriated facility protocol. 4. Resident #16 was 03/25/2017 and diagonysician's order da Resident #16 receiv 38 units in the evenion 04/26/2017 at 4: Levemir pen was ob medication cart read and undated. On 04/26/2017 at 4: conducted with Nurse Levemir pen located Resident #16 was us by another nurse per should be supposed to the supposed facility protocol.						

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			D W//NO				c	
		345191	B. WING			04/	29/2017	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SURRY C	OMMUNITY HEALTH A	ND REHAB CENTER			542 ALLRED MILL ROAD			
OUNTER O	JIIIII JIII II II II II II II II II II I	NO REIND GENTER			MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 431	Continued From pa	ge 34	F	431				
	Pens was she state	ed she did not know. She						
	· ·	did not know when Levemir						
		the refrigerator and opened						
		pel would have indicated the						
		at she did not know when						
	· ·	emir pen was opened. She						
		an opened date she was						
		e if Resident #16's Levemir						
		or to the last administration of						
	Levemir on 04/25/2	017 and that injectable						
	medication should be	be removed from the cart and						
	discarded when it is	s expired. She immediately						
	removed the undate	ed Levemir pen from the						
	200hall medication	cart and discarded it.						
	On 04/26/2017 at 5	:00PM a review of the MAR						
	revealed that Resid	ent #16 received Levemir 38						
		7 at 8:00PM per physician's						
	orders as indicated MAR.	by documentation on the						
	On 04/26/2017 at 5	:20PM an interview was						
		ADON who stated that her						
		e nursing staff would have						
	•	oen for Resident #16 when it						
		facility policy. She stated that						
		s that the nursing staff, per						
		uld have checked that						
		emir pen was dated when						
		rsing staff would have						
		dent #16's Levemir pen was						
		ened and would have to be						
		dministration because without						
	· •	re was no way to determine						
		pen had expired. Her prompt						
		place a copy of the facility						
		in Storage Recommendation						
		of September 29, 2014 on top						
		carts and in their information iside of their cart as a						
	reference.	iside di tileli cart as a						
	reference.							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45404	D MINO			- 1	С	
		345191	B. WING			04/	/29/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
SURRY C	OMMUNITY HEALTH	AND REHAB CENTER		542 A	LLRED MILL ROAD			
0011111		7.11.5 N.E.1.71.5 GENTER		MOU	NT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 431	Continued From p	age 35	F	431				
	1	2:00PM an interview was						
		e DON who stated that her						
		hat the nursing staff would have						
	1 .	pens per facility policy and						
		Iministered medication to a						
	resident without a	known expiration date. She						
	stated that they in	itiated reeducation of all staff on						
		first and second shift that						
		ation cart checks will be done						
		ON, Staff SDM and MDS nurse						
		y night on third shift checking for						
	1 .	f medications, insulin and						
		d dating when opened and						
	•	dure Sunday nights on third have all medications in the						
	building per physic							
		2:46PM an interview with the						
		st along with DON stated that						
		that all insulin should be labeled						
		ately when removed from						
		knowing the difference in how						
		ould be discarded and this						
	information can be	e found in the facility policy.						
	On 04/29/2017 at	11:30AM an interview with the						
		conducted and stated that it is						
	· ·	at nurses administer, label and						
		medication when opened per						
		ed that the DON and ADON						
		ucation to the nursing staff in						
		ion dates of open medication on						
		s within the facility and that the						
		en place with the nursing staff						
		second shifts on 04/26/2017 and atil all nursing staff had been						
		pecified that his expectation is						
		nistering insulin to Resident #16,						
		check that the insulin had been						
		tely with an opened date as per						
	facility protocol.	an opened date do pol						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 BOILE			، ا	2	
		345191	B. WING				29/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 047	29/2017	
	1011211 011 001 1 21211				2 ALLRED MILL ROAD			
SURRY CO	OMMUNITY HEALTH A	AND REHAB CENTER			OUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 431	Continued From pa	age 36	F	431				
	04/06/2017 and dia physician's order of Resident #17 receipen Suspension por 12 units SQ in the 6 On 04/26/2017 at 4 Novolog 70/30 Mix 200 hall medication opened and undate On 04/26/2017 at 4 conducted with Nu had used the Novolog 70 she did not know a 70/30 Mix expired refrigerator. She cowould have indicated she did not know a 70/30 Mix Pen was opened date she was Resident #17's Novexpired prior to her 70/30 Mix on 04/26 did not look for the medication should discarded when it is removed the undated from the 200 hall medication on 04/26/2017 at 8 revealed that Resid 70/30 Mix 10 units physician's orders on the MAR.	e:45PM Resident #17's pen was observed on the cart ready for use and was ed. e:45PM an interview was rse #1. She stated that she elog 70/30 Mix Pen located on or Resident #17 for the en asked what the expiration 0/30 Mix Pen was, she stated and did not know when Novolog once opened and out of the onfirmed that a dated label ed the date opened and that when Resident #18's Novolog sopened and without an vas unable to determine if volog 70/30 Mix Pen had r administering the Novolog 6/2017. She confirmed that she dated label and that injectable be removed from the cart and s expired. She immediately ed Novolog 70/30 Mix Pen edication cart and discarded it. 6:00PM a review of the MAR dent #17 received Novolog on 04/25/2017 at 9:41PM per as indicated by documentation						
	On 04/26/2017 at 5	5:20PM an interview was ADON who stated that her						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345191	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	0.0.0.		STREET ADDRESS, CITY, STATE, ZIP CODE)4/29/2017	
				542 ALLRED MILL ROAD	-		
SURRY C	OMMUNITY HEALTH AN	ID REHAB CENTER		MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 431	Continued From pag	ue 37	F 4	31			
	expectation was the dated the Novolog 7 #17 when it was ope stated that her expersaff, per facility prot that Resident #17's I dated when opened have identified that I Mix Pen was not dat have discarded prior insulin because with was no way to determ Mix Pen had expired to place a copy of th Storage Recommens September 29, 2014 carts and in their infoinside of their cart as On 04/27/2017 at 2:conducted with the Expectation was that labeled the insulin powould have not admiresident without a kinstated that they initia 04/27/2017 during finannounced medication daily by DON, ADON and every Monday in expiration dates of multidose vials and of match back procedus shift to ensure we have building per physicia On 04/27/2017 at 2:colinical Pharmacist and is expectation is that	nursing staff would have 0/30 Mix Pen for Resident ened as per facility policy. She ctation was that the nursing ocol, would have checked Novolog 70/30 Mix Pen was and that nursing staff would Resident #17's Novolog 70/30 ed when opened and would to administration of the out an opened date there mine when the Novolog 70/30 l. Her prompt action plan was e facility policy entitled Insulin dation with a revision date of on top of all 4 medication ormation notebook located as a reference. DOPM an interview was DON who stated that her at the nursing staff would have eens per facility policy and inistered medication to a nown expiration date. She ated reeducation of all staff on east and second shift that on cart checks will be done on, Staff SDM and MDS nurse ight on third shift checking for nedications, insulin and dating when opened and re Sunday nights on third ave all medications in the	F 4				

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345191	B. WING			C)4/29/2017	
NAME OF F	ROVIDER OR SUPPLIER	0.0.0.	 	STREET ADDRESS, CITY, STATE, ZIP CODE		14/29/2017	
				542 ALLRED MILL ROAD			
SURRY C	OMMUNITY HEALTH AN	ND REHAB CENTER		MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 431	Continued From pag	ge 38	F 4	31			
	long until they shoul information can be for On 04/29/2017 at 11 Administrator was considered in the expectation that date all necessary may policy. He confirmed had initiated reeduca regards to expiration the medication carts education had taken working first and secons would continue until reeducated. He specthat prior to administ staff should have chalbeled appropriately facility protocol. 6. On 04/26/2017 at revealed on 1 of 4 m three Lidocaine multi Water for injection mand not labeled or divials were on the caa. On 04/26/2017 at Nurse #3 revealed to the multi dose vials were available cart and that any meand undated should She stated that the value a new one wher 3 Lidocaine vials peb. On 04/26/2017 at Nurse #3 revealed to the stated that the value a new one wher 3 Lidocaine vials peb. On 04/26/2017 at Nurse #3 revealed to the stated that the value and was a revealed to the	d be discarded and this bound in the facility policy. :30AM an interview with the conducted and stated that it is nurses administer, label and nedication when opened per I that the DON and ADON ation to the nursing staff in a dates of open medication on within the facility and that the place with the nursing staff cond shifts on 04/26/2017 and all nursing staff had been cified that his expectation is tering insulin to Resident #17, eck that the insulin had been with an opened date as per 5:10PM an observation nedication carts on 300hall, it dose vials and one Sterile nulti dose vial were opened ated with open date. These ret at ready for use. 5:10PM an interview with the insulin had been with open date. These ret at ready for use. 5:10PM an interview with the she did not know when of Lidocaine was opened and object of an opened evial. She confirmed that the to use on 300hall medication edication or vial that is opened not be given to any resident. Vials should be discarded and in needed. She discarded the	F 4				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345191	B. WING		C 04/29/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0-1/20/2011
CUDDY C		ND DELIAD CENTED		542 ALLRED MILL ROAD	
SURRYC	OMMUNITY HEALTH A	IND REHAB CENTER		MOUNT AIRY, NC 27030	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICY)	D BE COMPLETION
F 431	Continued From pa	ige 39	F 431		
F 431	expiration date of a dose vial. She conf vial was available a medication cart and that is opened and to any resident. She vial should be discassed to any resident of the vial should be discassed to any resident. She vial should be discassed to any resident of the vial should be discassed to any resident of the vial should be discassed to any resident of the vials when they we and that the all nurre medication on their for use had been last of the vials when they we and that the all nurre medication carts and the vials when they we and that the all nurre for use had been last of the vials when they we and that the all nurre medication carts are notebook located in reference. On 04/27/2017 at 2 conducted with the expectation was that labeled the multing the would have remove medication carts to and unlabeled medication cart check the control of the vials of vials of the vials o	n opened Sterile Water multi irmed that the Sterile Water and ready for use on 300hall d that any medication or vial undated should not be given e stated that the Sterile Water arded. She discarded the	F 431		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	BUILDING		OMPLETED
		345191	B. WING_			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		04/29/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 431	Continued From pag	je 40	F 4	31		
	back procedure Sun ensure we have all r physician order. On 04/29/2017 at 11 Administrator was consisted in expectation that date all necessary molicy. He confirmed had initiated reeduca regards to expiration the medication carts education had taken working first and sec would continue until reeducated. He specunlabeled medication removed and discard per facility policy. Again same commentation of the molicity policy. Again same commentation of the multi dose will was available to a. On 04/26/2017 at Nurse #4 revealed the multi dose vial was available to cart and that any meand undated should She stated that the vuse a new one wher Lidocaine vial per fab. On 04/26/2017 at Nurse #4 revealed the Novolog Pen was belonged and did not belo	day nights on third shift to medications in the building per 3:30AM an interview with the onducted and stated that it is nurses administer, label and hedication when opened per 1 that the DON and ADON ation to the nursing staff in a dates of open medication on within the facility and that the place with the nursing staff cond shifts on 04/26/2017 and all nursing staff had been beined that all opened and in should be immediately ded from all medication carts on 100hall, dose vial and one unlabeled pened and available for use. 5:15PM an interview with the she did not know when at Lidocaine was opened and object of an opened evial. She confirmed that the use on 100hall medication or vial that is opened not be given to any resident. Vial should be discarded the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		(С	
		345191	B. WING				29/2017	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
				5	42 ALLRED MILL ROAD			
SURRY C	OMMUNITY HEALTH	AND REHAB CENTER		N	MOUNT AIRY, NC 27030			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	ID PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	ΙΕ	(X5) COMPLETION	
TAG	REGULATORY (OR LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	DATE	
F 431	Continued From pa	age 41	F.	431				
	Novolog Pen was	available and ready for use on						
		cart and that any medication						
	or vial that is open	ed and undated should not be						
	given to any reside	ent. She stated that the Novolog						
	Pen should be disc	carded. She discarded the						
	Sterile Water vial p	per facility policy.						
	On 04/26/2017 at \$	5:20PM an interview was						
	conducted with the	ADON who stated that her						
	expectation was th	e nursing staff would have						
		e and labeled and dated the						
		n they were opened as per						
		hat her expectation was that						
		f check that any medication on						
		ened and ready for use had						
		an opened date. She stated her						
		at nursing staff would remove						
		dated vials from their						
		er prompt plan of action was to						
	' ' '	e facility policy entitled Insulin						
		endation with a revision date of						
	l .	14 on top of all 4 medication						
		nformation notebook located						
	inside of their cart							
		2:00PM an interview was						
		e DON who stated that her						
		at the nursing staff would have						
		ose vial and Novolog Pen per						
		vould have removed the vial						
		nedication carts to prevent use						
		l unlabeled medication. She						
		tiated reeducation of all staff on						
		first and second shift that						
		edication cart checks will be						
		I, ADON, Staff SDM and MDS						
		londay night on third shift						
		ation dates of medications,						
		ose vials and dating when						
		back procedure Sunday nights						
	on third shift to ens	sure we have all medications in						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLIED (X3) DATE						
				_		,	c
		345191	B. WING			04/	29/2017
	ROVIDER OR SUPPLIER DMMUNITY HEALTH AND	O REHAB CENTER		54	TREET ADDRESS, CITY, STATE, ZIP CODE 42 ALLRED MILL ROAD 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441 SS=E	Administrator was conhis expectation that in date all necessary metapolicy. He confirmed had initiated reeducate regards to expiration the medication carts we education had taken pworking first and seconducated. He special unlabeled medication removed and discarding per facility policy. 483.80(a)(1)(2)(4)(e)(PREVENT SPREAD, (a) Infection prevention The facility must estate and control program (a minimum, the follow) (1) A system for prevenivestigating, and concommunicable diseases volunteers, visitors, a providing services un arrangement based us conducted according accepted national state implementation is Phase (2) Written standards	cian order. 30AM an interview with the inducted and stated that it is urses administer, label and edication when opened per that the DON and ADON tion to the nursing staff in dates of open medication on within the facility and that the blace with the nursing staff and shifts on 04/26/2017 and all nursing staff had been fied that all opened and should be immediately ed from all medication carts f) INFECTION CONTROL, LINENS an and control program. blish an infection prevention (IPCP) that must include, at ving elements: enting, identifying, reporting, introlling infections and the ses for all residents, staff, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards (facility assessment)		441			5/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 04/29/2017
	ROVIDER OR SUPPLIER	ID REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	,	04/20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 441	Continued From pag	e 43	F 4	41		
	possible communica	illance designed to identify ble diseases or infections ad to other persons in the				
	1 1	om possible incidents of use or infections should be				
	(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;					
	(iv) When and how is resident; including b	solation should be used for a ut not limited to:				
	depending upon the involved, and (B) A requirement th	ration of the isolation, infectious agent or organism at the isolation should be the ible for the resident under the				
	must prohibit employ disease or infected s	es under which the facility yees with a communicable skin lesions from direct ts or their food, if direct the disease; and				
		e procedures to be followed irect resident contact.				
		ording incidents identified PCP and the corrective facility.				
	1 7 7	el must handle, store, ort linens so as to prevent the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			04/2	29/2017
	ROVIDER OR SUPPLIER	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	DDE		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIAT		(X5) COMPLETION DATE
F 441	annual review of its I program, as necessa This REQUIREMEN' by: Based on observation interviews the facility Control policy entitle residents on 2 of 4 h. Findings include: The policy for Contact 2012 indicates that I occurs when microordirectly from person Contact Transmission the infectious agent contaminated interm same policy also stated and 12: II. GLOVES AND HAAA. Hand hy prior to donning gloves the room while province. Gloves shaving contact with in D. Gloves shaving the resident's should be performed E. After gloves.	the facility will conduct an PCP and update their ary. T is not met as evidenced ons, record reviews and staff of failed to follow their Infection of "Contact Isolation" for alls (200 and 300 halls). The transmission of the person and Indirect of the person and Indirect of the person and Indirect of the person of the person. The test the following on pages 11 The transmission of the person of the perso	F 4	F441 483.80 Infection Cospread, Linens 1. Staff were immediately rehand washing, Contact Isol Personal Protective Equipm 2. All nursing, housekeeping office staff will be retrained washing, Contact Isolation a 05/26/2017. 3. Director of Nursing/Assis Nursing or designee will coron all halls to ensure compl 4 weeks, then monthly x 3. 4. All results will be brought months, or until no further is	e-educated of lation and nent (PPE). g, therapy ar on Hand and PPE by tant Director mplete audits iance weekly	on nd of s y x	

		OATE SURVEY COMPLETED				
		345191	B. WING _			04/29/2017
	PROVIDER OR SUPPLIER	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		0412312011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	entering the room o B. The go leaving the resident C. After re should not contact re environmental surfa VI. CONTACT I CONSIDRED FOR A. Multi dri MRSA, VRE, ESBL Acinetobacter baum B. Scabies C. Clostrid infections causes of D. Unconta Diagrams on pages proper PPE placem 1a. On 04/26/2017 a during supper meal CNA #8 had entered positioning resident washing hands or wequipment (PPE) ex Contact Isolation sig perform hand hygie On 4/26/2017 at 6:1 #8 revealed that she was okay to go in a when they should we all the time. She sta the door of room 31 pieces of PPE are to entering the room. Se wear gloves into the the tray table closer	r should be donned prior to r resident's cubicle. wn should be removed before 's s room. emoval of the gown, clothing potentially contaminate ices. PRECAUTIONS MAY BE (EXAMPLES): ug resistant organism (e.g. 's, KPCs, resist (mannii)) ium difficile and other diarrhea. ained draining wounds. 12 and 13 demonstrated	F 4	41		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLI		OMPLETED				
		345191	B. WING _			C 04/29/2017
	ROVIDER OR SUPPLIER	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		0-1/23/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 46	F 4	141		
	about what is exper room to deliver tray b. On 4/27/2017 at performed during si 200hall revealed CN with a meal tray, as and setup tray table wearing PPE even Isolation sign on the hand hygiene when c. On 4/26/17 at 6:2 CNA #10 had enter assist resident with table without washin even though there won the door and did when exiting the rood. On 4/26/17 at 6:2 the Assistant Direct entered room 212 versident with positionable without washin even though there won the door and did when exiting the rood when exiting the rood the Admissions Marto setup bedside tray thands or wearing P Contact Isolation signerform hand hygie room. f. On 4/26/17 at 6:3 CNA #10 had enterwith bedside tray ta washing her hands though there was a	cted of staff when entering a s. 6:15PM an observation upper meal tray pass on NA #10 had entered room 205 sist resident with positioning without washing hands or chough there was a Contact a door and did not perform exiting the room. 10PM an observation revealed and room 212 with a meal tray, positioning and setup tray and her hands or wearing PPE was a Contact Isolation sign not perform hand hygiene om. 125PM an observation revealed for of Nursing (ADON) had with a meal tray, assist uning and setup bedside tray and her hands or wearing PPE was a Contact Isolation sign not perform hand hygiene om. 125PM an observation revealed for of Nursing (ADON) had with a meal tray, assist uning and setup bedside tray and her hands or wearing PPE was a Contact Isolation sign not perform hand hygiene om. 125PM an observation revealed the perform hand entered room 205 by table without washing her PE even though there was a grip on the door and did not one when exiting the same 125PM an observation revealed and room 206 to assist resident to be and meal setup without or wearing any PPE even Contact Isolation sign on the form hand hygiene when 125PM and hygiene when 126PM and hygiene hygiene hygiene hygiene hygiene				

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		SURVEY PLETED
						С
		345191	B. WING		04	/29/2017
	OVIDER OR SUPPLIER	DELIAR CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD		
SURRICC	MMUNITY HEALTH AND	REMAD CENTER		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) BE	(X5) COMPLETION DATE
F 520 SS=D	in-service log dated F staff received educati Control with a focus of proper PPE use, cross and disposal of isolati On 04/27/2017 at 5:12 Director of Nursing (Dexpectation is that all Isolation guidelines seresident room door reentering the room. Shinitiated reeducating sand Contact Isolation 04/27/2017. On 04/29/2017 at 11:: Administrator reveale that all staff adhere to policy and follow the cas instructed at all time contamination. 483.75(g)(1)(i)-(iii)(2)(COMMITTEE-MEMBI QUARTERLY/PLANS) (g) Quality assessment (1) A facility must mai and assurance comminimum of: (ii) The director of nurse (iii) At least three otherstaff, at least one of we staff, at least one of we staff, at least one of we staff, at least one of we staff.	OPM, a review of staff rebruary 2017 revealed that on regarding Infection on infection control policies, is contamination, glove use on. 5PM, an interview with the ON) revealed that her staff follow the Contact ret in place and posted on the gardless of the reason for re also stated that they staff about Infection Control starting on 2nd shift on 30AM an interview with the d that it is his expectation of the facility Infection Control Contact Isolation guidelines res to prevent cross (i)(ii)(h)(i) QAA ERS/MEET Int and assurance. Intain a quality assessment wittee consisting at a sing services; ter members of the facility's		520		5/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 04/29/2017
NAME OF PROVIDER OR SUPPLIER SURRY COMMUNITY HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		0-112012011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (X5 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5 COMPLE DAT	
F 520			F 5	520		
	individual in a leadership role; and (g)(2) The quality assessment and assurance committee must :					
	coordinate and evalu	terly and as needed to late activities such as h respect to which quality urance activities are				
		ement appropriate plans of stified quality deficiencies;				
	Secretary may not re records of such com such disclosure is re	rmation. A State or the equire disclosure of the mittee except in so far as lated to the compliance of the requirements of this				
	sanctions.					
	Based on observation facility's Quality Asset Committee failed to monitor the intervent into place on March, deficiency, which was (F323) on a complain deficiency was in the was cited again on 4 complaint survey. The facility during two surveys.	ons and staff interviews, the essment and Assurance maintain procedures and ions that the committee put 2017. This was for recited soriginally cited in accident at survey on 3/16/2017. The area of F323. This deficiency 1/29/2017 on a follow up and the continued failure of the riveys showed a pattern of the sustain an effective Quality		F520 □ 483.75 QAA Comm Members/Meet Quarterly/Pla 1. A QAPI meeting will be he 5/24/2017 to discuss F323 (a of Accident Hazards/Supervi and develop an immediate p improvement and to ensure being maintained. 2. The District Director of Cli will provide education to the members. Education will be	eld on 483.25 Free ision/Devices) lan for practices are nical Services QAPI	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		345191	B. WING _			04/29/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
SLIDBY	MMIINITY HEALTH AND	DEHAR CENTER		542 ALLRED MILL ROAD			
SURRY COMMUNITY HEALTH AND REHAB CENTER				MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED DEFICI	(X5) COMPLETION DATE		
F 520	Continued From page 49		F 5	20			
	Assurance (QA) Program.			5/24/17.			
	Finding Included:			The District Director of will randomly review QA attend meetings when p	API minutes and		
	This tag is cross refer	renced to		QAPI committee will me than the required quarte	· ·		
	staff interview the factor adequate supervision (activities of daily living combative resident with confusion and lacerate resident's reviewed for a confusion and lacerate resident's reviewed for a confusion, physicial record review, the fact additional assistance, resident with combating an injury while providing was agitated, moving head on the side port Resident #1 was sent change in condition with subdural hematoma (hematoma was made one resident in a same The Administrator was at 5:30 PM. His would be re-educated again de-escalation and president with resident and president and	when providing ADL care ag) to an agitated and hich resulted in a fall with a ion to the head for 1 of 3 or accidents (Resident #2). survey of 3/16/2017 the ccident (F 323). Based on an and staff interviews and cility failed to call for a provide interventions for a ve during care, and prevent ing care when Resident #1 about in bed and struck her ion of the metal side rail. It out to the hospital after a vas noted. A diagnosis of a brain bleed) and a at at the hospital. This was apple of three with accidents. Is interviewed on 4/29/2017 It expect that all staff would on combativeness and evention. He stated that he to identify areas of concern		meeting at least weekly x 3 months. The weekly on the requirements of t (483.25 Free of Acciden Hazards/Supervision/De committee will develop a process improvements a correction as needed. 4. All results will be broumonths, or until no furth.	x 4, then monthly meeting will focus the tag F323 at evices) and the an action plan for and deficiency		

Facility ID: 953479