PRINTED: 01/09/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  THREE RIVERS HEALTH AND REHAB  SUMMANY STATEMENT OF DEPICISACISES (1717, STATE, ZIP CODE 1403 CONNER DRIVE WINDSOR, NC 27983)  PRETIX SUMMANY STATEMENT OF DEPICISACISES (1624) DEPICISACY MUSTS SEE PRECISCIBLY STULL)  FREGULATORY OR LISC IDENTIFYING INFORMATION)  F 550  Resident Rights/Exercise of Rights  CFR(s): 483.10(a) (712/D(c)/1/2)  \$483.10(a) (Resident Rights)  The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.  \$483.10(a)(1) A facility must treat each resident with respect and dignify and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must resident and practices regardless of diagnosis, severity of condition, or payment source.  \$483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source.  \$483.10(b) Exercise of Rights.  The resident has the right to exercise his or her rights as a resident of the facility and as a clitzen or resident of the United States.  \$483.10(b) (2) The facility must ensure that the resident can exercise his or her rights as a resident of the facility and as a clitzen or resident of the United States.			(X3) DATE SURVEY COMPLETED				
THREE RIVERS HEALTH AND REHAB  (NATION   100   1			345404	B. WING _		_	C 12/05/2017
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SS=D  CFR(s): 483.10(a)(1)(2)(b)(1)(2)  §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.  §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.  §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BI	COMPLETION
rights and to be supported by the facility in the  ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DATE	SS=D	CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a ri self-determination, a access to persons an outside the facility, in this section.  §483.10(a)(1) A facil with respect and dignesident in a manner promotes maintenan her quality of life, recindividuality. The fac promote the rights of  §483.10(a)(2) The face access to quality can severity of condition, must establish and in practices regarding the provision of services residents regardless  §483.10(b) Exercise The resident has the rights as a resident con resident of the Un  §483.10(b)(1) The face resident can exercise interference, coercio from the facility.  §483.10(b)(2) The refree of interference, reprisal from the faci rights and to be supposed.	Rights. Ight to a dignified existence, and communication with and and services inside and ancluding those specified in the services inside and and in an environment that are or enhancement of his or cognizing each resident's illity must protect and are regardless of diagnosis, or payment source. A facility must provide equal are regardless of diagnosis, or payment source. A facility maintain identical policies and aransfer, discharge, and the under the State plan for all of payment source.  Of Rights.  I right to exercise his or her of the facility and as a citizen ited States.  I will the service of the facility must ensure that the ensurement of the facility must ensurement of the facility ens				

Electronically Signed 12/23/2017

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		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345404	B. WING		C 12/05/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/05/2017
				1403 CONNER DRIVE	
THREE RI	VERS HEALTH AND REI	HAB		WINDSOR, NC 27983	
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F 550	Continued From page	e 1	F 550	0	
	subpart. This REQUIREMENT by:	rights as required under this  is not met as evidenced  n, record review, and staff		F550	
	and resident interview maintain dignity by fa ask permission to ent 24 residents observe #23, Resident #7, Re Resident #22, Reside			The statements made on this plan of correction are not an admission to ar not constitute an agreement with the alleged deficiencies.  To remain in compliance with all fede and state regulations the facility has or will take the actions set forth in thi	eral taken s
	Findings included:  1. Resident #2 was a 3/30/17.	dmitted to the facility on		plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	
	I .	2's most recent quarterly sessment dated 7/6/17 derately cognitively		Plan for correcting specific deficient.  The process that led to deficiency cit.  The facility failed to maintain dignity.  The facility failed to maintain dignity.	ed.
	House Keeper #1 ent without knocking and side of the bed beside During an interview o	n 11/29/17 at 11:52 AM		failing to knock on doors or asked permission to enter resident rooms to of 24 residents observed. The identification employees that failed to knock on resideors was immediately provided education by the Environmental Service Director on 11-29-2017.	ïed sident
	the doors were close	ted that she knocked when d but she did not have to er presence if the doors		The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: -	
	Resident #2 stated shaped before entering her rostated that she would	n 11/29/17 at 12:03 PM ne wanted staff to knock first com for privacy. She further not want staff entering but some staff did always		On 12-12-17, The Administrator, Dire of Nursing, Housekeeping and Laund Supervisor, began in servicing all FT and PRN RN's, LPN's, CNA's and Housekeeping and Laundry Staff and	dry , PT,

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	BUILDING COMP		ATE SURVEY DMPLETED
		345404	B. WING		,	C <b>12/05/2017</b>
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				1403 CONNER DRIVE		
THREE RI	VERS HEALTH AND RE	НАВ		WINDSOR, NC 27983		
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F 550	Continued From page	e 2	F 55	50		
	they would always kr	f did not and she wished lock. She stated that she lock if the door was open or		Rehab Staff, Dietary Staff and Department Managers on the fo procedures:	-	
	Director of Nursing si knock or announce the entering a resident's was her expectation knock or announce the entering a resident's was open or closed. continued stating for	room. She further stated it was that all staff would neir presence before room no matter if the door The Director of Nursing residents who were		Honoring Resident Preferences- Respecting resident's private sp property (e.g.,not changing radio television station without resider permission, knocking on doors a requesting permission to enter, doors as requested by the resid- moving or inspecting resident's possession without permission.	oace and o or nt's and closing ent, not	
	their presence and the During an interview of Environmental Service housekeeping staff of any room and annour regardless of if the dostated that for reside impaired, his expects announce their present this was a dignity corshould have knocked	staff should still announce at it was a dignity concern.  In 11/29/17 at 12:51 PM the rese Director stated that must knock before entering ince their presence for was open or closed. He into the work of the staff would rece. He further stated that incern and House Keeper #1 If prior to entering each room.		Any in-house staff member who receive in-service training by 12 will not be allowed to work until has been completed. This inform been integrated into the standar orientation training and in the re in-service refresher courses for employees and will be reviewed Quality Assurance process to ve the change has been sustained.  The monitoring procedure to entitle plan of correction is effective specific deficiency cited remains	training mation has rd quired all by the erify that sure that e and that	
	9/30/16.  Review of Resident # data set assessment was assessed as mo impaired.  During observation o House Keeper #1 en	23's most recent minimum dated 10/6/17 revealed she		and/or in compliance with the re requirements:  The Administrator, Director of N MDS Coordinator, Central Supp Restorative Aid, Environmental Director will conduct audits to er are knocking on doors or asking permission to enter residents roweekly for two weeks and month	egulatory ursing, bly Clerk, Services nsure staff oms,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345404	B. WING				C <b>05/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	03/2017
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F 550	Continued From page 3  During an interview on 11/29/17 at 11:52 AM House Keeper #1 stated that she knocked when the doors were closed but she did not have to			550	months. This monitoring will continue or resolved by QOL/QA committee. Reported to the weekly QA committee by the Administrator or DOI	orts	
	were open.	er presence if the doors			ensure corrective action initiated as appropriate. Compliance will be monitorand ongoing auditing program reviewe	d at	
During an interview on 11/29/17 at 12:04 PI Resident #23 stated she would like staff to before entering even if the door is open. Sh further stated some staff did not always knobefore entering.  During an interview on 11/29/17 at 12:15 PI Director of Nursing stated staff must always knock or announce their presence before entering a resident's room. She further state was her expectation was that all staff would knock or announce their presence before		she would like staff to knock if the door is open. She staff did not always knock on 11/29/17 at 12:15 PM the tated staff must always heir presence before room. She further stated it was that all staff would heir presence before	o knock he lock PM the vs		the weekly QA Meeting. The weekly Q Meeting is attended by the Administrat DON, MDS Coordinator, Therapy, HIM and the Dietary Manager.  The title of the person responsible for implementing the plan of correction.  The Administrator is responsible for implementation and completion of the acceptable plan of correction.	or,	
	was open or closed. continued stating for cognitively impaired, their presence and the	room no matter if the door The Director of Nursing residents who were staff should still announce nat it was a dignity concern. on 11/29/17 at 12:51 PM the					
	housekeeping staff nany room and annou regardless of if the d stated that for reside impaired, his expectannounce their present its was a dignity conshould have knocked	ces Director stated that must knock before entering nce their presence oor was open or closed. He nts who were cognitively ation was his staff would ence. He further stated that ncern and House Keeper #1 d prior to entering each room.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION  G	(X3	B) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER VERS HEALTH AND RE	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DRIVE WINDSOR, NC 27983	:	12/00/2011
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F 550	data set assessment resident was assess  During observation of House Keeper #1 en without knocking or a During an interview of House Keeper #1 state doors were close knock or announce hwere open.  During an interview of Director of Nursing sknock or announce tentering a resident's was her expectation knock or announce tentering a resident's was open or closed. continued stating for cognitively impaired, their presence and the During an interview of Environmental Servithousekeeping staff of any room and annouregardless of if the direction of the service of	#7's most recent minimum c dated 8/24/17 revealed the ed as cognitively intact.  In 11/29/17 at 11:51 AM Intered Resident #7's room Innouncing her presence.  In 11/29/17 at 11:52 AM Intered that she knocked when Indicated that she knocked when Intered that she did not have to Interpresence if the doors  In 11/29/17 at 12:15 PM the Interest that all staff would Interpresence before Interest that all staff would Interpresence before Interest the door Interest that all staff would Interpresence before Interest that all staff would Interest the door Interest that all staff would Interest the door Interest that all staff would Intere	F 5			
	announce their prese this was a dignity co should have knocked During an interview of	ation was his staff would ence. He further stated that neern and House Keeper #1 d prior to entering each room.  on 11/29/17 at 2:25 PM the would appreciate staff				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	' '	DATE SURVEY COMPLETED
		345404	B. WING			C <b>12/05/2017</b>
	ROVIDER OR SUPPLIER VERS HEALTH AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE  1403 CONNER DRIVE  WINDSOR, NC 27983	<u> </u>	12/03/2017
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 550	knocking so that she room.  4. Resident #32 was 7/22/16.  Review of Resident # data assessment dat was assessed as seven buring observation of House Keeper #1 en without knocking or a buring an interview of House Keeper #1 state doors were close knock or announce house of announce to be buring a resident's was her expectation knock or announce the entering a resident's was open or closed. Continued stating for cognitively impaired, their presence and the buring an interview of Environmental Service.	admitted to the facility on  #32's most recent minimum ted 10/22/17 revealed she verely cognitively impaired.  In 11/29/17 at 11:43 AM tered Resident #32's room announcing her presence.  In 11/29/17 at 11:52 AM ated that she knocked when ad but she did not have to her presence if the doors  In 11/29/17 at 12:15 PM the tated staff must always heir presence before room. She further stated it was that all staff would heir presence before room no matter if the door The Director of Nursing	F 55	0		
	stated that for reside	nce their presence oor was open or closed. He nts who were cognitively ation was his staff would				

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	ROVIDER OR SUPPLIER VERS HEALTH AND RE	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DRIVE WINDSOR, NC 27983		12/03/2017
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F 550	Continued From pag	je 6	F 5	50		
	this was a dignity co	ence. He further stated that ncern and House Keeper #1 d prior to entering each room.				
	5. Resident #9 was a 5/29/13.	admitted to the facility on				
	data set assessmen	#9's most recent minimum t dated 9/5/17 revealed he verely cognitively impaired.				
	House Keeper #1 er	on 11/29/17 at 11:49 AM ntered Resident #9's room announcing her presence.				
	House Keeper #1 state the doors were close	on 11/29/17 at 11:52 AM ated that she knocked when ed but she did not have to her presence if the doors				
	Director of Nursing s knock or announce t entering a resident's was her expectation knock or announce t entering a resident's was open or closed. continued stating for cognitively impaired.	on 11/29/17 at 12:15 PM the stated staff must always their presence before room. She further stated it was that all staff would their presence before room no matter if the door. The Director of Nursing residents who were staff should still announce that it was a dignity concern.				
	Environmental Servi housekeeping staff r any room and annou regardless of if the d	on 11/29/17 at 12:51 PM the ces Director stated that must knock before entering unce their presence loor was open or closed. He ents who were cognitively				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LE CONSTRUCTION		COMPLETED
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	ROVIDER OR SUPPLIER	ЕНАВ		STREET ADDRESS, CITY, STATE, ZIP CODE  1403 CONNER DRIVE  WINDSOR, NC 27983	<u> </u>	12/03/2017
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F 550	announce their pre this was a dignity of should have knocked.  6. Resident #22 was 6/30/16.  Review of Resident data set assessme was assessed as s  During observation House Keeper #1 of without knocking of  During an interview House Keeper #1 s the doors were close knock or announce were open.  During an interview Director of Nursing knock or announce entering a resident' was her expectatio knock or announce entering a resident' was open or closed continued stating for	ge 7 ctation was his staff would sence. He further stated that oncern and House Keeper #1 ed prior to entering each room.  It sadmitted to the facility on the stated 10/7/17 revealed he everely cognitively impaired.  It so 11/29/17 at 11:51 AM entered Resident #22's room announcing her presence.  If on 11/29/17 at 11:52 AM entered that she knocked when sed but she did not have to her presence if the doors  If on 11/29/17 at 12:15 PM the stated staff must always their presence before s room. She further stated it in was that all staff would their presence before s room no matter if the door it. The Director of Nursing or residents who were di, staff should still announce	F 55	· · · · · · · · · · · · · · · · · · ·		
	During an interview Environmental Sen housekeeping staff any room and anno	that it was a dignity concern.  on 11/29/17 at 12:51 PM the vices Director stated that must knock before entering bunce their presence door was open or closed. He				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345404	B. WING				05/2017
	ROVIDER OR SUPPLIER VERS HEALTH AND REH	HAB		14	TREET ADDRESS, CITY, STATE, ZIP CODE 403 CONNER DRIVE /INDSOR, NC 27983		00.2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	impaired, his expecta announce their prese this was a dignity conshould have knocked 7. Resident #29 was 7/7/17.  Review of Resident # data set dated 10/14/ was assessed as sev During observation of House Keeper #1 ent without knocking or a During an interview of House Keeper #1 state doors were closed knock or announce howere open.  During an interview of Director of Nursing st knock or announce the entering a resident's was her expectation of knock or announce the entering a resident's was open or closed. Continued stating for cognitively impaired, their presence and the During an interview of Environmental Service.	nts who were cognitively tion was his staff would nce. He further stated that idern and House Keeper #1 prior to entering each room.  admitted to the facility on  29's most recent minimum 17 revealed the resident erely cognitively impaired.  In 11/29/17 at 11:51 AM ered Resident #29's room nnouncing her presence.  In 11/29/17 at 11:52 AM ted that she knocked when do but she did not have to er presence if the doors  In 11/29/17 at 12:15 PM the ated staff must always heir presence before room. She further stated it was that all staff would heir presence before room no matter if the door The Director of Nursing residents who were staff should still announce at it was a dignity concern.  In 11/29/17 at 12:51 PM the less Director stated that lust knock before entering	F	550			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345404	B. WING		C <b>12/05/2017</b>
	ROVIDER OR SUPPLIER VERS HEALTH AND RE		140	REET ADDRESS, CITY, STATE, ZIP CODE 03 CONNER DRIVE INDSOR, NC 27983	12/03/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 550	regardless of if the do stated that for resider impaired, his expecta announce their present is was a dignity corshould have knocked.  8. Resident #40 was 2/22/11.  Review of Resident #4 data set assessment resident was assessimpaired.  During observation on House Keeper #1 enwithout knocking or a without knocking or a buring an interview of House Keeper #1 state doors were close knock or announce hwere open.  During an interview of Director of Nursing state knock or announce the entering a resident's was her expectation knock or announce the entering a resident's was open or closed. Continued stating for cognitively impaired, their presence and the During an interview of During an interview of cognitively impaired, their presence and the During an interview of the state of	cor was open or closed. He hats who were cognitively stion was his staff would ence. He further stated that incern and House Keeper #1 prior to entering each room.  Admitted to the facility on each of the ence	F 550		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345404	B. WING _			C <b>12/05/2017</b>	
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F 550	any room and annou regardless of if the do stated that for resider impaired, his expecta announce their preset this was a dignity corshould have knocked 9. Resident #6 was a 2/13/04.  Review of Resident #6 data set assessment resident was assessed impaired.  During observation on House Keeper #1 enwithout knocking or a buring an interview of House Keeper #1 states the doors were close knock or announce howere open.  During an interview of Director of Nursing significant was her expectation was her expectation knock or announce the entering a resident's was open or closed. continued stating for cognitively impaired,	nust knock before entering noe their presence for was open or closed. He into who were cognitively ation was his staff would ence. He further stated that incern and House Keeper #1 If prior to entering each room.  Idmitted to the facility on the facility of the facility of the facility of the facility on the facility of the facility	F 5	50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345404	B. WING				05/2017
	ROVIDER OR SUPPLIER  VERS HEALTH AND REF	HAB		14	TREET ADDRESS, CITY, STATE, ZIP CODE 403 CONNER DRIVE VINDSOR, NC 27983	127	03/2017
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F 550	Environmental Service housekeeping staff many room and annour regardless of if the do stated that for resider impaired, his expectatannounce their preset this was a dignity conshould have knocked 10. Resident #34 was 12/16/14.  Review of Resident # data set assessment resident was assessed impaired.  During observation of House Keeper #1 ent without knocking or a During an interview of House Keeper #1 stated the doors were closeknock or announce howere open.  During an interview of Director of Nursing st knock or announce the entering a resident's was her expectation of knock or announce the entering a resident's was open or closed. Continued stating for	n 11/29/17 at 12:51 PM the es Director stated that cust knock before entering nee their presence for was open or closed. He ents who were cognitively tion was his staff would nee. He further stated that foern and House Keeper #1 prior to entering each room.  admitted to the facility on  34's most recent minimum dated 10/25/17 revealed the ed as severely cognitively  11/29/17 at 11:52 AM ered Resident #34's room nnouncing her presence.  11/29/17 at 11:52 AM ted that she knocked when d but she did not have to er presence if the doors  11/29/17 at 12:15 PM the ated staff must always feir presence before froom. She further stated it was that all staff would feir presence before froom no matter if the door The Director of Nursing	F	550			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  3	· ,	ATE SURVEY OMPLETED
		345404	B. WING			C 1 <b>2/05/2017</b>
	ROVIDER OR SUPPLIER VERS HEALTH AND RE	нав		STREET ADDRESS, CITY, STATE, ZIP CODE  1403 CONNER DRIVE  WINDSOR, NC 27983		12/03/2017
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F 550	During an interview of Environmental Service housekeeping staff in any room and annour regardless of if the distated that for reside impaired, his expects announce their present this was a dignity conshould have knocked 11. Resident #28's with 4/5/17.  Review of the Resident minimum data set as revealed the resident cognitively impaired.  During observation of Nurse Aide #1 did not before she entered Fill During an interview of Nurse Aide #1 states or announce their progresident's room regal or closed and get performed in the progression of Nursing significant interview of Director of Nursing signif	and it was a dignity concern.  In 11/29/17 at 12:51 PM the ces Director stated that must knock before entering nee their presence for was open or closed. He into who were cognitively ation was his staff would ence. He further stated that incern and House Keeper #1 diprior to entering each room.  In as admitted to the facility on the ent #28's most recent esessment dated 10/12/17 at was assessed as severely the entering and the ence here in the ence here in the ence in the ence here in the ence here.  In 11/29/17 at 12:15 PM the ence here in the	F 58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345404	B. WING			12/	05/2017
	ROVIDER OR SUPPLIER VERS HEALTH AND REH	······································		14	TREET ADDRESS, CITY, STATE, ZIP CODE 103 CONNER DRIVE VINDSOR, NC 27983		
(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 584 SS=D	their presence and th Safe/Clean/Comforta CFR(s): 483.10(i)(1) §483.10(i) Safe Envir The resident has a rig comfortable and hom but not limited to rece supports for daily livir The facility must prov	residents who were staff should still announce at it was a dignity concern. ble/Homelike Environment (7) onment. ght to a safe, clean, elike environment, including siving treatment and ng safely.		550			1/2/18
	homelike environmen use his or her person possible. (i) This includes ensu receive care and serv physical layout of the independence and do (ii) The facility shall e	clean, comfortable, and it, allowing the resident to all belongings to the extent ring that the resident can vices safely and that the facility maximizes resident pose not pose a safety risk, exercise reasonable care for resident's property from loss					
	services necessary to and comfortable inter §483.10(i)(3) Clean b in good condition; §483.10(i)(4) Private resident room, as spe	ed and bath linens that are					

AND DIANIOE CODDECTION IDENTIFICATION NUMBED:		1	IPLE CONSTRUCTION  IG	` '	(X3) DATE SURVEY COMPLETED	
		345404	B. WING _			C <b>12/05/2017</b>
	ROVIDER OR SUPPLIER VERS HEALTH AND RE	нав		STREET ADDRESS, CITY, STATE, ZIP COI 1403 CONNER DRIVE WINDSOR, NC 27983	DE	12/00/2011
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 584	Continued From pag	e 14	F 5	84		
	levels. Facilities initia	table and safe temperature ally certified after October 1, a temperature range of 71 to				
	sound levels.	maintenance of comfortable Γ is not met as evidenced				
	Based on observation facility failed to appropriate equipment by storing bathroom grab bars apan wedged between for 3 of 15 bathrooms	ons and staff interviews, the opriately store resident care unmarked urinals on and floor, and a specimen on the grab bar and the wall as reviewed, and failed to		F584 The statements made on this correction are not an admiss not constitute an agreement alleged deficiencies.	ion to and do with the	
	reviewed.  The findings included	control for 1 of 24 residents		To remain in compliance with and state regulations the factor will take the actions set for plan of correction. The plan of correction and the facility is also as a set of the facility in the state of the facility is also as a set of the facility in the state of the facility is also as a set of the facility in the state of the facility is also as a set of the facility in the state of the facility is also as a set of the facility in the state of the set of th	ility has taken rth in this of correction	
	3:44 PM, 11/29/17 at at 11:30 AM of the sh	e made on 11/28/2017 at 2:16 PM and on 11/30/2017 nared bathroom located and 208. Two unmarked		constitutes the facility's alleg compliance such that all alle deficiencies cited have been corrected by the dates indica	ged or will be	
		d in the bathroom, one b bar and one laying on it's		Plan for correcting specific     The process that led to defic	iency cited.	
	3:20 PM, 11/29/17 at at 11:30 AM of the sh between rooms 209 a specimen pan was of the grab bar and the 3. Observations were 3:40 PM, 11/29/17 at at 11:30 AM of the sh	e made on 11/28/2017 at 2:22 PM and on 11/30/2017 hared bathroom located and 211. An uncovered bserved wedged between wall.  e made on 11/28/2017 at 2:25 PM and on 11/30/2017 hared bathroom located and 216. Two urinals were		The facility failed to appropri- resident care equipment by s unmarked urinals on bathroo and floor, and specimen pan wedged between the grab ba wall for 3 of 15 bathrooms re failed to change a frayed be of 24 residents reviewed. a. The unmarked urinals and specimen pans were discard immediately on 11-30-17 by Nursing and the Central Sup	storing om grab bars as were ar and the eviewed and d control for 1  If the led the Director	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345404	B. WING				05/2017	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	00/2017	
				14	403 CONNER DRIVE			
THREE RI	VERS HEALTH AND REI	HAB		W	VINDSOR, NC 27983			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 584	Continued From page	e 15	F	584				
	observed in the bathr	oom, both hanging from the			b. The frayed bed control was replaced	on		
		arked with a resident name			12-11-2017 by the Environmental			
	and the other was un	marked.			Services Director.			
	4. Observations were	made on 11/29/17 at 8:43			On 12-1-17, the Director of Nursing and	t		
		PM and on 11/30/17 at			Central Supply Clerk conducted an aud	lit		
		control cord for room 210A.			of all Resident rooms to include			
		was wrapped around the left			bathrooms to ensure resident care			
		ored wires were visible			equipment was properly stored.			
	under the cracked wir	re covering.			The Environmental Services director conducted an audit of all Resident roor			
	An interview with nurs	se side (NA) #3 was			to ensure bed controls are in good	15		
		7 at 11:52 AM. The NA		working order. 12-22-2017				
		ecimen pans were stored in			Working Order. 12 22 2017			
		er the bathrooms or in the						
	resident's night stand				2. The procedure for implementing the			
	_	amaged or needed repair			acceptable plan of correction- for the			
	was written up for the	maintenance manager.			specific deficiency cited: -			
		se #3 was conducted on			On 12-12-17, The Administrator, Direct			
		. The nurse stated she			of Nursing, Housekeeping and Laundry			
	,	e residents on the 200 hall.			Supervisor, began in servicing all FT, F	PT,		
		als and specimen pans			and PRN RN's, LPN's, CNA's and			
		h the resident name. Any			Housekeeping and Laundry Staff and			
	· ·	ipment not working would			Rehab Staff, Dietary Staff and			
	be reported to the ma	lintenance director.			Department Managers on the following procedures:			
		#4 was conducted on						
	11/30/17 at 12:57 PM				- The resident has a right to a safe cle			
		sidents on the 200 hall. The			comfortable and homelike environment			
		specimen pans should be			including but not limited to receiving			
		name. Any exposed wires or			treatment and supports for daily living			
		g would be reported to the			safely.	aro		
	maintenance director				-The importance of labeling resident careful equipment, such as urinals and storing	ai <del>C</del>		
	An interview was con	ducted with the director of			them properly.			
		30/17 at 4:09 PM. The			- The importance of inspecting and			
		nd specimen pans should be			reporting any signs of frayed bed control	ols		
		ent's name and placed in a						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER VERS HEALTH AND RE		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE  1403 CONNER DRIVE	12/05/2017
THINEE IN	VERO HEALITIAND RE			WINDSOR, NC 27983	
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F 584	plastic bag and not unhanging on the grabher expectation of stated it was her expectation of stated it was her expectation.	ge 16  unmarked on the floor or bars. The DON stated it was aff to properly mark and ecimen pans. The DON pectation of staff to report any ols to maintenance for repair.	F 58	Any in-house staff member who did not receive in-service training by 12-31-20 will not be allowed to work until training has been completed. This information been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify the the change has been sustained.  The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements:  The Administrator, Director of Nursing, MDS Coordinator, Central Supply Cler and Restorative Aid, Environmental Services Director will conduct audits on Resident rooms and bathrooms to ensure sident care equipment is properly stand the resident bed controls are in goworking order.  These audits will be completed weekly two weeks and monthly for 3 months. In monitoring will continue until resolved QOL/QA committee. Reports will be presented to the weekly QA committee the Administrator or DON to ensure corrective action initiated as appropriated Compliance will be monitored and ongoing auditing program reviewed at weekly QA Meeting is attended by the Administrated DON, MDS Coordinator, Therapy, HIM and the Dietary Manager.  The title of the person responsible for	17, ghas has has has has has has has has has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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THREE RI	VERS HEALTH AND REI	IAB			403 CONNER DRIVE /INDSOR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 584	Continued From page	e 17	F s	584	implementing the plan of correction.  The Administrator is responsible for implementation and completion of the acceptable plan of correction.			
F 600 SS=D	S483.12 Freedom fro Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's me \$483.12(a) The facilit \$483.12(a)(1) Not use physical abuse, corpor involuntary seclusion. This REQUIREMENT	m Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This aited to freedom from involuntary seclusion and ical restraint not required to edical symptoms.  y must- e verbal, mental, sexual, or oral punishment, or	F	600			1/2/18	
	and record review the pressure ulcer and in care until five days af	y, and physician interviews, e facility failed to identify a itiate pressure ulcer wound ter admission to the facility viewed for pressure ulcer			The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies.	do		
	#57 from the discharg	e instructions for Resident ging medical center dated the facility on 11/14/17 7 had an unstageable			To remain in compliance with all federa and state regulations the facility has tak or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged	ken		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	wound to her right lat measured 1 centimet wide, and no depth. T wound with normal sa	e 18 eral ankle. The wound er long 1.5 centimeters The order was to cleanse the aline, pat dry, and cover with ay, Wednesday, Friday, and	F	600	deficiencies cited have been or will be corrected by the dates indicated.		
	11/15/17. Her active of fibrillation, hyperlipide hemiplegia.  Review of Resident #	57's admission nursing			F 600 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:	e	
	was assessed as at r ulcers. Resident #57' "good" with normal sk	/15/17 revealed the resident isk to develop pressure is skin was assessed to be kin care required, including a ment. Wound care was not ed.			The facility failed to identify pressure ul and initiate pressure ulcer wound care until five days after admission to the facility for 1 of 2 residents reviewed for pressure ulcer care.		
	for pressure ulcer devincluded to observe the redness or open area areas were noted and skin assessments.  Review of Resident # assessment dated 11 #57 was assessed to Review of skilled nurs 11/17/17, 11/18/17, a Resident #57 was no	e resident was care planned velopment. The interventions he resident 's skin for s and inform nurse if any d perform weekly full body  57's dietitian nutritional /16/17 revealed Resident have no wounds.			A full body assessment was completed 100% of in house residents on 11-30-2017. DON, MDS Coordinator, a licensed nurses assessed for any pressure ulcers/skin concerns and to ensure MD orders for wound care. 100 of resident charts were reviewed for current treatment orders on identified s conditions on 11-30-2017 by MDS Coordinator. Pressure and nonpressur wound UDA completed on residents the had pressure ulcers/skin concerns identified on 11-30-2017 by MDS Coordinator.  On 11-30-17 the Director of Nursing published 1009/c of the following:	and 0% kin re	
		ressure ulcer assessment led that an initial pressure			audited 100% of the following:  All current residents had a full body ski assessment completed all areas noted		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/03/2017	
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THREE RI	VERS HEALTH AND RE	HAB		WINDSOR, NC 27983			
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F 600	Continued From pag	e 19	F 600				
	Resident #57. The or documented to be 11 be community acquir assessed to have on ankle. The wound was unstageable pressur measurements were centimeters wide, an was 100% slough. The an unstagable, sloug outer ankle. The area reddened and slightly was noted at that tim well defined. A dress be changed every 2 family was notified or Review of Resident # revealed that treatments.	e ulcer. The wound 0.9 centimeters long, 1.4 d had no depth. The tissue ne note stated resident had h covered wound to her right a around wound was y edematous. No drainage e. The wound edges were ing was applied and was to days. The physician and		were reviewed for a current tre order on current resident Pres UDA/non pressure UDA comp current residents This audit was completed on a with the following findings of to without treatment orders for no identified areas. These two we immediately corrected with ord for wound care, UDA complete notified. This was completed of 12-1-2017 by MDS Coordinate nurse.  The procedure for implementing acceptable plan of correction of specific deficiency cited:  On 12-12-2017 the Director of began in servicing all FT, PT, RN's, LPN's, Med Tech's, and	ssure wound sleted on 12-1-2017 wo residents ewly ere ders in place ed and RP on or and staff and the for the		
	Data Set (MDS) asserve aled she was assunderstood with mod required limited assist transfers. Resident # part with bathing. Shounstageable pressurupon admission and long, 1.4 centimeters.  During an interview of Resident #57's family pressure ulcer on he before arrival in the fore	#57's most recent Minimum essment dated 11/22/17 sessed as rarely or never ified independence. She stance with bed mobility and 57 required physical help in e was assessed to have one e ulcer which was present measured 0.9 centimeters wide, and no depth.  In 11/28/17 at 11:27 AM or stated Resident #57 had a right ankle which developed acility. The family stated that nedical center on 11/14/17		Importance of clinical docume assure that all potential risks resident safety care are met, I musts be fully and accurately  All UDAs must be completed a scheduled time frames. (i.e. A quarterly, annually, readmissic significant change in status)  Completion of weekly skin/ we assessment and the proper we conduct skin UDA (head to too resident unclothed.)	entation to related to UDA's completed. within Admission, on, and with		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 600	Continued From page	e 20	F 600			
F 600	and arrived on 11/15/stated the facility did for six days until she #1's attention on 11/2 the bandage from the present when staff log 11/20/17. The family unsure if the wound hit did appear to have however the wound wourrently looked much buring an interview of Nurse Aide #2 stated who was working who admitted. She further needed some assistating the nurse aides bather was working who was working who admitted the nurse aides bather the state of the facility	117 at the facility. She further not notice the pressure ulcer brought it to MDS Nurse 20/17 and the wound still had a prior medical center oked at the wound on continued to state she was nad actually gotten worse but more redness on 11/20/17, was healing now and h better than it ever had.  In 11/30/17 at 11:14 AM that she was the nurse aide en Resident #57 was stated Resident #57 unce with bathing and that ed her legs and feet and her	F 600	Review of facility protocol on documentation of wounds and the inclusion of measurements, location, drainage amount, signs of infection for UDA completion.  Review with nursing staff importance promptly reporting changes to skin or wounds, notification of physician, residents RP notification.  Any in-house staff member who did no receive in-service training by 12/31/20	of oot 017	
	concerns on Residen 11/16/17 during care. again until the next M wound was discovered. During an interview of Nurse #1 stated that to him on 11/20/17 ar facility was doing for stated he went to the wound. MDS Nurse #1 that was on Resident that time was not a discovered house. He concluded Resident #57's right of from 11/14/17 or before wound doctor and de wound doctor ordered the wound every two	She stated she did not work londay, 11/20/17 when the		will not be allowed to work until training has been completed. This information been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify the change has been sustained.  The monitoring procedure to ensure the plan of correction is effective and specific deficiency cited remains correction in compliance with the regulator requirements:  The Director of Nursing or MDS Coordinator will audit UDA weekly for weeks then monthly for three months completion of the skin wound UDAs. monitoring will continue until resolved QOL/QA committee.; Reports will be	n has  d  ne nat  hat that that ected ory  two for This I by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345404	B. WING _			C / <b>05/2017</b>	
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F 600	assessed the wou was unable to iden wound prior to 11/did not believe the the facility before on the day the res was the nurse who audited her admis did not identify the finished the admis nurse.  During an intervied Director of Nursing expectation that a head to toe assess stated that staff shoressure ulcer on through record revassessment, it wan not identified until MDS Nurse #1's at During a phone in Nurse #1 stated sulcer on Resident it was her second by her trainer that nursing home, nurfull body assessment feeding tube site. Nurse #2 and she admitted Resident During an intervied Director of Nursing Nurse #1 but Nurs	nd. He further stated that he ntify any documentation of the 20/17 and stated due to this, he wound had been identified by 11/20/17. He further stated that ident was admitted Nurse #1 admitted the resident and he sion assessment. He stated he pressure ulcer when he sion assessment audit for the sion at 1/30/17 at 1:42 AM the greatest would have a full sments upon entry. She further sould have identified the Resident #57 upon admission view as well as a full head to toe is not done, and the wound was the family member brought it to attention on 11/20/17.  Iterview on 11/30/17 at 1:33 PM the did not identify the pressure #57's right outer ankle because day of training and she was told on the rehab section of the reses did not have to complete a tent and she only needed to assessment on Resident #57's She stated her trainer was was with her that day when she	F 6	presented to the weekly QA the Administrator or DON to corrective action initiated a Compliance will be monitor ongoing auditing program r weekly QA Meeting. The w Meeting is attended by the DON, MDS Coordinator, Th and the Dietary Manager.  The title of the person resp implementing the plan of co The Administrator is respor implementation and comple acceptable plan of correction	o ensure s appropriate. red and reviewed at the reekly QA Administrator, herapy, HIM, ronsible for porrection. herible for etion of the		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION  G	COMPLETED	
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	ROVIDER OR SUPPLIER VERS HEALTH AND RE	НАВ	STREET ADDRESS, CITY, STATE, ZIP CODE  1403 CONNER DRIVE  WINDSOR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION	
F 600	11/15/17. She further been told to not perform assessment on a resunit of the facility.  During a phone intervolves #2 stated that not work on 11/15/17 no time during the trainer that full head to to required on the rehalt.  During a phone intervolves when the Wound Care Physaw the wound it was	king independently on stated that no staff had ever	F 60	00		
F 622 SS=D	wound bed. She state wound before 11/22/if the wound had dete saw on her initial ass the lack of dressing of impacted the status of point. She further state dressing on pressure cause a decline in the #57's wound did not of deteriorating tissue Transfer and Dischar CFR(s): 483.15(c)(1) \$483.15(c)(1) Facility (i) The facility must premain in the facility, discharge the resider (A) The transfer or di	ed having not seen the 17 she could not say for sure eriorated but from what she essment on 11/22/17 she felt changes had not negatively of the pressure ulcer at that ted not changing the wounds had the potential to e wound, however Resident have any indications or signs a.  The requirements (i)(ii)(2)(i)-(iii)  The requirements or requirements or requirements or requirements or remit each resident to	F 62	22	1/2/18	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	· '	OMPLETED
		345404	B. WING _			C <b>12/05/2017</b>
	ROVIDER OR SUPPLIER VERS HEALTH AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DRIVE WINDSOR, NC 27983	1	12/03/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 622	because the resident sufficiently so the resident sufficiently so the resident services provided by (C) The safety of indicendangered due to the status of the resident (D) The health of indicentering of the resident has appropriate notice, to under Medicare or Sident who become admission to a facility resident only allowable or (F) The facility may not resident while the ap § 431.230 of this charge notice from 431.220(a)(3) of this discharge or transfer or safety of the reside facility. The facility methat failure to transfer §483.15(c)(2) Docum When the facility transfer or safety under any or	facility; scharge is appropriate 's health has improved dident no longer needs the the facility; viduals in the facility is ne clinical or behavioral grividuals in the facility would ered; failed, after reasonable and o pay for (or to have paid edicaid) a stay at the facility. If the resident does not or paperwork for third party third party, including dr, denies the claim and the eay for his or her stay. For a es eligible for Medicaid after or, the facility may charge a ele charges under Medicaid; sto operate. Out transfer or discharge the peal is pending, pursuant to pter, when a resident ight to appeal a transfer or in the facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the foust document the danger or or discharge would pose.	F 6	22		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345404	B. WING		C <b>12/05/2017</b>	
	ROVIDER OR SUPPLIER VERS HEALTH AND RI	EHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DRIVE WINDSOR, NC 27983	12/00/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 622	or discharge is documedical record and communicated to the institution or provide (i) Documentation in must include:  (A) The basis for the (i) of this section.  (B) In the case of pasection, the specific be met, facility atterneeds, and the servifacility to meet their (ii) The documentat (2)(i) of this section (A) The resident's passis passis in the discharge is necess (A) or (B) of this section (B) A physician when necessary under passis section.  (iii) Information provimust include a minimust includ	must ensure that the transfer imented in the resident's appropriate information is e receiving health care er.  In the resident's medical record the transfer per paragraph (c)(1) (i)(A) of this resident need(s) that cannot into the entation must be made by hysician when transfer or ary under paragraph (c) (1) (ii)(C) or (D) of the ided to the receiving provider mum of the following: tion of the practitioner care of the resident.  The properties of the resident including over information including are graph (c)(2) as applicable, and into as applicable, to ensure information, as applicable, to ensure	F 622			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345404	B. WING		C <b>12/05/2017</b>
	ROVIDER OR SUPPLIER	ЕНАВ		STREET ADDRESS, CITY, STATE, ZIP CODE  1403 CONNER DRIVE  WINDSOR, NC 27983	12/03/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 622	(RP) and facility state facility failed to allow behaviors to remain discharge notice who the meet the reside 108) of 3 residents.  The findings included A review of the Adu 8/291/17 revealed Fewhich included demicisorder and cerebrathe right dominant states.	It Care Home FL2 form dated Resident #108 had diagnoses nentia, syncope, seizure ral infarct with hemiparesis of	F 622	The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies.  To remain in compliance with all fede and state regulations the facility has or will take the actions set forth in this plan of correction. The plan of correctionstitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	ral taken s tion
	8/30/17 revealed the wandering, had not and was chair fast at the resident was not appear to be adjust Resident #108 did nonce every hour. He hydration and had be another nursing not by the Director of Notelephone call was to "discuss other opnote also stated the facility inability to addiscussed and the contact of the state of	al Risk Assessment dated e resident did not exhibit wandering in the last 7 days and not able to walk.  d 8/31/17 at 3:37 AM revealed wadmission and did not ing well. The note stated not sleep and had been up e had been offered a snack, been toileted.  the written on 8/31/17 at 11:56 ursing (DON) revealed a made to the resident's doctor officions for resident care." The exit seeking behavior and commodate his needs was doctor was agreeable with a placement for the resident.		Plan for correcting specific deficiency process that led to deficiency cited.  The facility failed to allow a resident wexit seeking behaviors to remain in the facility by issuing a discharge notice stated the facility could not meet the resident's needs. Resident #108 was admitted on 8-30-2017. FL-2 and me records were shared with facility prior 8-30-2017, and resident was admitte 8-30-2017. A Pre-admission medical records did not disclose that resident an active frequent exit seeker and capable of working through exit seek barriers, such as a wanderguard systi	with ne which dical r to d on al was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BOILDI			, ا	C
		345404	B. WING			1	05/2017
NAME OF P	ROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				14	103 CONNER DRIVE		
IHKEE KI	VERS HEALTH AND REI	нав		W	/INDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	on 12/1/17 at 10:37 A had exit seeking behat the service hall looking that he had syncope falls. She said the far inform him they were safety. The DON statt should do what was the said Resident 108 was which alarmed when An interview was con Administrator on 12/1 Resident #108 was "Naround." She stated "He was more than wappropriate for our far #108 was more approached the Administrator also dementia unit because that she gave the RP A review of the Nursing Transfer/Discharge reand the date of dischinds placement." The transfer/discharge was welfare and your nee facility." The form also transfer or discharge nursing home facility address and phone in	with the Director of Nursing and she stated Resident #108 aviors and even went onto any for an exit. She added and was at increased risk for cility contacted the doctor to afraid for Resident #108's ed the doctor said they pest for the resident. She as wearing a Wander Guard he got near the front door.  ducted with the //17 at 1:36 PM. She stated wery busy and wandering she told the resident's RP we could handle and not cility." She added Resident appriate for a locked unit. The said she felt he needed a see he was an exit seeker and a discharge notice.  Ing Home Notice of evealed it was dated 8/31/17 arge was "as soon as facility ereason for as "It is necessary for your discannot be met in this so stated the plans to was to another named and the form had the umber of that facility. The	F	622	Resident was admitted on 8-30-2017. Assessments were completed to identically risk and resident scored as a low risk within twenty four hours, resident becausery active and was repetitively exit seeking and the wanderguard system who to effective for resident. Communicating with RP and MD to discuss appropriate level of care and specialty units that material accommodate residents need. A 30 da DC was issued to allow and support timeded to address resident's exit seek behaviors and/or specialty unit. RP material the decision to take resident back to his previous facility on 8-31-2017.  The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: -	sk. me vas on ay y ne ing de	
	care ombudsman's co	opeal rights and long term ontact information. The he administrator and dated			The facility will offer Resident #108 to return back into the facility.		
	During a telephone in	iterview with Resident #108's			During the admissions process, Social		

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		0.5101			С	
		345404	B. WING _		12/05/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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ITINEE KI	VERS HEALTH AND KER	IAD		WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE COMPLÉTION	
F 622	F 622 Continued From page 27 RP on 12/5/17 at 1:30 pm she stated she had visited the facility during a weekend prior to admission. Resident 108's RP said she received a telephone call from the facility stating there was a bed available. She stated she drove Resident #108 from the adult care home to the nursing home in her car. The RP also stated she was not able to complete the admission paperwork on 8/30/17 because the social services/admission coordinator was not available. Resident #108's RP added that as she was driving back to the facility on 8/31/17 to complete the admission paperwork, she received a telephone call from the Administrator who told her the facility was not able to care for her father because he was a liability due to his wandering behaviors. The RP did say she had provided the facility with medical information for her father on 8/30/17.  Resident # 108 was discharged on 8/31/17.		F 63	Worker, Social Services assistant at Activities Director will conduct Residenterviews to obtain information abor Residents preferences regarding activities, leisure time and going out Involve the IDT, resident and/or residenteresentative in developing a dischaplan that reflects the resident's curredischarge needs, goals, and treatmenteresences while considering caregistations about their interest in receiving information about returning to the community;  Assist the resident and/or resident representatives in selecting a post-activities.	dent dent arge ent ent jiver	
				care provider if the resident went to another SNF (skilled nursing facility (nursing home), HHA (home health agency), IRF (inpatient rehab facility LTCH (LTC hospital).  Education for the Interdisciplinary To (including Social Worker, Admission Nursing, MDS Coordinator) was conducted by the Administrator, to	eam	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		345404	B. WING _			12/	05/2017
NAME OF PRO	OVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
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IHREE RIV	ERS HEALTH AND REF	IAB		W	/INDSOR, NC 27983		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
F 000	0 " 15						
F 622	Continued From page	28	F 6	322			
					include:		
					Discharge processing and assessment including documentation requirements	,	
					Processes of issuing 30 day Dc notices	<u>.</u>	
					and communication to Resident/RP	,	
					Any in-house staff member who did no receive in-service training by 12-31-20 will not be allowed to work until training	17,	
					has been completed. This information been integrated into the standard		
					orientation training and in the required in-service refresher courses for all employees and will be reviewed by the		
					Quality Assurance process to verify that the change has been sustained.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTF AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345404	B. WING		C 12/05/2017	
	ROVIDER OR SUPPLIER VERS HEALTH AND REM	L		STREET ADDRESS, CITY, STATE, ZIP CODE  1403 CONNER DRIVE  WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI  REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 622	Continued From page	e 29	F 622	The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correspond or in compliance with the regulator requirements:	hat cted	
				Discharge Audits will be conducted by Admissions, Social Services Assistant MDS Coordinator, Health Information Manager or Director of Nursing on Residents discharged from the facility. These audits will be conducted to ens the discharge has the appropriate discharge and discharge documentation.	, ure	
				These audits will be conducted weekly two weeks and monthly for 3 months. monitoring will continue until resolved QOL/QA committee. Reports will be presented to the weekly QA committee the Administrator or DON to ensure corrective action initiated as appropria Compliance will be monitored and ongoing auditing program reviewed at weekly QA Meeting. The weekly QA Meeting is attended by the Administra DON, MDS Coordinator, Therapy, HIM and the Dietary Manager.	This by e by te. the	
				The title of the person responsible for implementing the plan of correction.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345404	B. WING		C 12/05/2017	
	ROVIDER OR SUPPLIER VERS HEALTH AND REF	IAB	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DRIVE NINDSOR, NC 27983	1 12/03/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION	
F 622	F 622 Continued From page 30		F 622			
F 641	Accuracy of Assessm	onte	F 641	The Administrator is responsible for implementation and completion of the acceptable plan of correction.	e 1/2/18	
SS=D	CFR(s): 483.20(g)	ents	F 041		1/2/16	
	resident's status. This REQUIREMENT by: Based on observation record review the factoresident's toilet use a quarterly minimum dat (Resident #30) and a quarterly minimum dat (Resident #24) for 2 coresident assessments  Findings included:  1. Resident #30 was 8/17/17. His active did dementia, gout, and a Review of Resident # minimum data set (M 10/14/17 revealed in marked as activity on	is not met as evidenced  ns, staff interview, and lity failed to correctly code a nd eating abilities on a ata set assessment resident's toilet use on a ata set assessment of 7 residents reviewed for s.  admitted to the facility on agnoses included vascular		F641 The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all fede and state regulations the facility has or will take the actions set forth in this plan of correction. The plan of correctionstitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.  Plan for correcting specific deficiency process that led to deficiency cited.  The facility failed to correctly code a resident's toilet use and eating abilities a quarterly minimum data set	eral taken s tion e	
	Resident #30 was ob	n 11/28/17 at 12:20 PM served to be eating in his nce only was required.		assessment(Resident #30) and a resident's toilet use on a quarterly minimum data set assessment(Resid #24) for 2 of 7 residents reviewed.	lent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345404	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	040404	1 2	<u> </u>	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	05/2017
NAME OF PI	ROVIDER OR SUPPLIER						
THREE RI	VERS HEALTH AND REF	IAB			403 CONNER DRIVE		
			W	VINDSOR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ARY STATEMENT OF DEFICIENCIES ID FICIENCY MUST BE PRECEDED BY FULL PREF RY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					32.18.2.18.1		
F 641	Continued From page	31	F	641			
					The procedure for implementing the		
	During an interview o	n 11/30/17 at 4:00 PM Nurse			acceptable plan of correction- for the		
	Aide #1 stated that Re	esident #30 required limited			specific deficiency cited:		
		s and needed extensive					
		se. She further stated that			The MDS consultant in-serviced the MI		
		ver had a feeding tube. The			Coordinator and Director of Nursing on		
		to state that Resident #30			the following procedures:		
	had not gone a day w	vithout voiding.					
	Duning an interview a	- 44/20/47 -+ F:02 DM MDC			How to accurately code Section G0110		
	During an interview on 11/30/17 at 5:03 PM MDS  Nurse #1 stated that they were having				and G0110I (Toilet Use and Eating) on MDS assessment.	trie	
		s with the nurse aides. He			MDS assessment.		
		that provided care for the			The two resident MDS' were corrected		
		ook back period of 7 days			electronically by the MDS Coordinator.		
		the resident's eating and			and the second and th		
		ivity that only occurred once			This information has been integrated in	ito	
		rked at the facility and			the standard orientation training for MD		
	because of this they	could not change this			Coordinator and will be reviewed by the	e	
		rther stated this was the			Quality Assurance process to verify that	t	
		data set assessment dated rately reflect Resident #30's			the change has been sustained.		
	status.				The monitoring procedure to ensure the		
					the plan of correction is effective and the		
		n 12/1/17 at 9:02 AM the			specific deficiency cited remains correct		
	_	ated it was her expectation			and/or in compliance with the regulator	y	
	that MDS Nurse #1 w				requirements:		
		sessments were correct and nation was identified by			The MDS Consultant, Director of Nursi	na	
		t should be corrected. She			MDS Coordinator, will conduct audits to		
		imum data set assessment			ensure accurate coding of Section G	,	
	for Resident #30 was				(G0110H and G0110I) of MDS		
		d have been corrected.			assessments, weekly for two weeks an	ıd	
					monthly for 3 months. This monitoring		
	2. Resident #24 was	admitted to the facility on			continue until resolved by QOL/QA		
		agnoses included heart			committee. Reports will be presented to	<b>o</b>	
	failure, muscle weakr				the weekly QA committee by the		
					Administrator or DON to ensure correct	tive	
		24's most recent quarterly			action initiated as appropriate.		
	minimum data set ass	sessment dated 10/7/17			Compliance will be monitored and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345404	B. WING	B. WING		C <b>12/05/2017</b>	
NAME OF PE	ROVIDER OR SUPPLIER	010101	1	STREET ADDRESS, CITY, STATE, ZIP CODE	12/	05/2017	
TO THE OTHER	TO VIDEIX OIX OUT I EIEIX			1403 CONNER DRIVE			
THREE RI	VERS HEALTH AND REF	HAB		WINDSOR, NC 27983			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 641	Continued From page	e 32	F 64	1			
	activity only occurred  During an interview of	n 11/30/17 at 4:00 PM Nurse		ongoing auditing program reviewed a weekly QA Meeting. The weekly QA Meeting is attended by the Administr DON, MDS Coordinator, Therapy, HI	ator,		
	aide continued to stat	with toilet use. The nurse e that Resident #24 had not		and the Dietary Manager.  The title of the person responsible fo implementing the plan of correction.	r		
	Nurse #1 stated that the documentation issues stated the nurse aide resident during that loand documented that an activity that only or longer worked at the they could not change	n 11/30/17 at 5:03 PM MDS they were having s with the nurse aides. He that provided care for the took back period of 7 days the resident's toilet use was occurred once or twice no facility and because of this this documentation. He		The Administrator is responsible for implementation and completion of the acceptable plan of correction.	e		
	data set assessment accurately reflect Res  During an interview of Director of Nursing states that MDS Nurse #1 w minimum data set assif inaccurate documer MDS Nurse #1 then it further stated the min for Resident #24 was	ident #24's status.  n 12/1/17 at 9:02 AM the ated it was her expectation rould ensure that the sessments were correct and intation was identified by a should be corrected. She imum data set assessment incorrect and the					
F 686 SS=D	Treatment/Svcs to Pro CFR(s): 483.25(b)(1)( §483.25(b) Skin Integ §483.25(b)(1) Pressu	rity re ulcers. hensive assessment of a	F 68	6		1/2/18	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345404	B. WING		C <b>12/05/2017</b>
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE  1403 CONNER DRIVE  WINDSOR, NC 27983	12/03/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 686	professional standard pressure ulcers and of ulcers unless the indidemonstrates that the (ii) A resident with professional star promote healing, presence ulcers from deverthis REQUIREMENT by:  Based on staff, familiand record review the pressure ulcer and in care until five days at for 1 of 2 residents recare. (Resident #57)  Findings included:  Review of wound car #57 from the dischard 11/2/17 and faxed to revealed Resident #5 wound to her right lat measured 1 centimet wide, and no depth. Wound with normal stafoam dressing Mondars needed.  Resident #57 was additional resident #57 wa	s care, consistent with dis of practice, to prevent does not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent ndards of practice, to went infection and prevent eloping.  This is not met as evidenced  y, and physician interviews, e facility failed to identify a litiate pressure ulcer wound for admission to the facility eviewed for pressure ulcer  e instructions for Resident ging medical center dated the facility on 11/14/17 for had an unstageable eral ankle. The wound er long 1.5 centimeters  The order was to cleanse the aline, pat dry, and cover with ay, Wednesday, Friday, and mitted to the facility on diagnoses included atrial	F 68	The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies.  To remain in compliance with all feder and state regulations the facility has to or will take the actions set forth in this plan of correction. The plan of correct constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.  F 686  The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:  The facility failed to identify a pressur	d do ral aken sion e
		57's admission nursing /15/17 revealed the resident		ulcer and initiate pressure ulcer woun care until five days after admission to facility for 1 of 2 residents reviewed for	the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		E) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THREE RI	VERS HEALTH AND REI	·IAB		1403 CONNER DRIVE			
				WINDSOR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 686	Continued From page	e 34	F 68	6			
	was assessed as at r	isk to develop pressure		pressure ulcer care.			
		s skin was assessed to be		'			
	"good" with normal sk	kin care required, including a					
	diabetic skin assessn	nent. Wound care was not		A 100 % audit was completed or	n all newly		
	identified to be require	ed.		admitted resident charts for full I	body		
				assessment, wound care orders			
	Review of Resident #			completion in the EMR on 11/30	/2017 by		
		e resident was care planned		DON and MDS Coordinator.			
	·	velopment. The interventions					
	included to observe the			0 44 00 47 11 5: 1 (A)	. •		
	redness or open areas and inform nurse if any			On 11-30-17 the Director of Nurs	sing		
		d perform weekly full body		audited 100% of the following:			
	skin assessments.			100% of newly admitted residen	to oborto		
	Review of Resident #	57's dietitian nutritional		were audited for wound care ord			
		/16/17 revealed Resident		compared with EMR for accuracy			
	#57 was assessed to			completion	ry arra		
	Review of skilled nurs	sing reviews dated 11/16/17,		100% audit completed on newly	admitted		
	11/17/17, 11/18/17, a			residents for Pressure wound Ul			
	Resident #57 was no	t identified to have any		pressure UDA completion.			
	wounds.						
				This audit was completed on 12			
		ressure ulcer assessment		by DON and MDS Coordinator v			
		led that an initial pressure		incident of missing orders. All ne	-		
		s performed 11/20/17 for		admitted residents with wound of			
		set dated for the wound was		orders upon admission had been	n		
		/15/17 and was identified to		accurately transcribed.			
		ed. Resident #57 was		The procedure for implementing	ı tho		
	ankle. The wound wa	e wound to the right outer		acceptable plan of correction for			
	unstageable pressure			specific deficiency cited:	u IC		
		0.9 centimeters long, 1.4		Specific deficiency cited.			
		d had no depth. The tissue		On 12-12-2017 the Director of N	Jursina		
		ne note stated resident had		began in servicing all FT, PT, ar	•		
	_	n covered wound to her right		RN's, LPN's, Med Tech's, and S			
	outer ankle. The area			Clerk on the following procedure			
		edematous. No drainage		J. Same			
		e. The wound edges were					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		E SURVEY IPLETED
			A. BOILDIN			С
		345404	B. WING _			_
NAME OF D	ROVIDER OR SUPPLIER	0.70.70.7		STREET ADDRESS, CITY, STATE, ZIP CO		2/05/2017
NAIVIE OF F	ROVIDER OR SUFFLIER				JDE	
THREE RI	VERS HEALTH AND I	REHAB		1403 CONNER DRIVE		
				WINDSOR, NC 27983		
(X4) ID PREFIX TAG					CORRECTION ION SHOULD BE HE APPROPRIATE Y)	(X5) COMPLETION DATE
F 686	Continued From p	age 35	F 6	886		
	well defined. A dre	essing was applied and was to		Proper way to conduct a sk	in UDA looking	
		2 days. The physician and		at resident from head to toe		
	family was notified	on 11/20/17.				
				Completion of weekly skin/		
		nt #57's treatment record		assessment and the proper	-	
		ment for the right outer ankle		conduct skin UDA (head to	toe looking at	
	·	as not ordered or started until		resident unclothed.)		
	11/20/17.			Importance of clinical decu	montation to	
	Paview of Pasider	nt #57's most recent Minimum		Importance of clinical docu assure that all potential risk		
		ssessment dated 11/22/17		resident safety care are me		
		assessed as rarely or never		musts be fully and accurate		
		odified independence. She		made so rany and accurate	.,	
		sistance with bed mobility and		Review of facility protocol of	on	
		t #57 required physical help in		documentation of wounds a		
	part with bathing.	She was assessed to have one		inclusion of measurements,	, location,	
		ure ulcer which was present		drainage amount, signs of i	nfection for	
		nd measured 0.9 centimeters		UDA completion.		
	long, 1.4 centimete	ers wide, and no depth.				
		44/00/47 - 1 44 07 484		Review with nursing staff in		
		w on 11/28/17 at 11:27 AM		promptly reporting changes wounds, notification of phys		
		nily stated Resident #57 had a nher right ankle which		residents RP notification.	sician,	
		arrival in the facility. The family		residents RF notification.		
		ident left the medical center on		Any in-house staff member	who did not	
		ed on 11/15/17 at the facility.		receive in-service training b		
		the facility did not notice the		will not be allowed to work u		
	pressure ulcer for	six days until she brought it to		has been completed. This is	nformation has	
	MDS Nurse #1's a	ttention on 11/20/17 and the		been integrated into the sta	ndard	
		e bandage from the prior		orientation training and in th		
		esent when staff looked at the		in-service refresher courses		
		7. The family continued to state		employees and will be revie		
		the wound had actually gotten		Quality Assurance process		
		pear to have more redness on the wound was healing now		the change has been sustai	mea.	
	i i	ed much better than it ever had.		The monitoring procedure to	o ensure that	
	and currently 100kg	ed mach better tridiffit ever fidu.		The monitoring procedure to the plan of correction is effective.		
	During an interviev	w on 11/30/17 at 11:14 AM		specific deficiency cited ren		
		ted that she was the nurse aide		and/or in compliance with the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345404	B. WING_			l	C <b>05/2017</b>	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	03/2017	
				14	403 CONNER DRIVE			
THREE RI	VERS HEALTH AND RE	HAB			VINDSOR, NC 27983			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From page	e 36	F 6	686				
	who was working who admitted. She further needed some assistathe nurse aides bathe back. She further state concerns on Residen 11/16/17 during care. again until the next M wound was discovered.  During an interview of Nurse #1 stated that to him on 11/20/17 arracility was doing for stated he went to the wound. MDS Nurse #1 that was on Resident that time was not a discovered that time was not a discov	en Resident #57 was stated Resident #57 nce with bathing and that ed her legs and feet and her ted she did not see any skin to #57 on 11/15/17 or She stated she did not work londay, 11/20/17 when the ed.  In 11/30/17 at 11:29 AM MDS Resident #57's family came and asked him what the Resident #57's wound. He room and assessed the eff further stated the dressing the facility had in the dressing that was on outer ankle must have been one. He stated he called the scribed the wound and the did dressings to be applied to days. The wound doctor lity on the 11/22/17 and He further stated that he or any documentation of the 17 and stated due to this, he bound had been identified by 20/17. He further stated that		586	requirements:  The Director of Nursing or MDS Coordinator will audit UDA weekly for to weeks then monthly for three months for completion of the skin wound UDAs. The monitoring will continue until resolved to QOL/QA committee. ¿ Reports will be presented to the weekly QA committee the Administrator or DON to ensure corrective action initiated as appropriat Compliance will be monitored and ongoing auditing program reviewed at weekly QA Meeting. The weekly QA Meeting is attended by the Administrate DON, MDS Coordinator, Therapy, HIM and the Dietary Manager.  The title of the person responsible for implementing the plan of correction.	or nis by by e. the		
	was the nurse who ac audited her admission did not identify the pro- finished the admission nurse.	nt was admitted Nurse #1 dmitted the resident and he n assessment. He stated he essure ulcer when he n assessment audit for the  n 11/30/17 at 11:42 AM the ated that it was her			acceptable plan of correction.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345404	B. WING			C <b>12/05/2017</b>	
NAME OF PROVIDER OR SUPPLIER  THREE RIVERS HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CO 1403 CONNER DRIVE WINDSOR, NC 27983	I DE	12/03/2017	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 686	expectation that all rehead to toe assessm stated that staff should pressure ulcer on Rethrough record review assessment, it was mot identified until the MDS Nurse #1's attended by Nurse #1's attended by her trainer that on nursing home, nurse full body assessment perform a focused as feeding tube site. Shourse #2 and she was admitted Resident #5 training an interview of Director of Nursing son Nurse #1 but Nurse #11/15/17 and Nurse #11/15/17. She further been told to not perform a phone interview of the facility.  During a phone interview of the facility.  During a phone interview of the facility.  During a phone interview of the facility.	esidents would have a full ents upon entry. She further ld have identified the sident #57 upon admission was well as a full head to toe ot done, and the wound was a family member brought it to intion on 11/20/17.  View on 11/30/17 at 1:33 PM did not identify the pressure 7's right outer ankle because y of training and she was told the rehab section of the stand she only needed to seessment on Resident #57's at stated her trainer was as with her that day when she stated that Nurse #2 did train #2 was not in the facility on #1 had completed her king independently on stated that no staff had ever	F	586			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
					(	С	
		345404	B. WING			12/	05/2017
NAME OF PROVIDER OR SUPPLIER  THREE RIVERS HEALTH AND REHAB				1	TREET ADDRESS, CITY, STATE, ZIP CODE 403 CONNER DRIVE VINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686 F 791 SS=D	saw the wound it was ulcer with necrotic tiss wound bed. She state wound bed. She state wound before 11/22/1 if the wound had dete saw on her initial asset the lack of dressing compacted the status of point. She further state dressing on pressure cause a decline in the #57's wound did not hof deteriorating tissue Routine/Emergency ECFR(s): 483.55(b)(1)-\$483.55 Dental Servic The facility must assist routine and 24-hour expensive states of each resulting points and the state plan) (ii) Emergency dental \$483.55(b)(2) Must, it assist the resident-(i) In making appoints	sician stated when she first an unstageable pressure sue covering most of the ed having not seen the 7 she could not say for sure priorated but from what she essment on 11/22/17 she felt thanges had not negatively for the pressure ulcer at that the ed not changing the est wounds had the potential to be wound, however Resident that eave any indications or signs to be est residents in obtaining emergency dental care.  Dental Srvcs in NFs and in obtaining emergency dental care.  accilities.  Tovide or obtain from an accordance with §483.70(g) ing dental services to meet sident: vices (to the extent covered gand services;  If necessary or if requested, ments; and ansportation to and from the		791			1/2/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	ULTIPLE CONSTRUCTION  LDING		(X3) DATE SURVEY COMPLETED	
		345404	B. WING _			C <b>12/05/2017</b>	
NAME OF PROVIDER OR SUPPLIER  THREE RIVERS HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DRIVE WINDSOR, NC 27983		12/00/2017	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 791	residents with lost or dental services. If a 3 days, the facility m what they did to ensuand drink adequately services and the extiled to the delay;  §483.55(b)(4) Must have circumstances when dentures is the facility charge a resident for dentures determined policy to be the facility services and wish to preimbursement of demedical expense under the control of th	referral does not occur within ust provide documentation of ure the resident could still eat while awaiting dental enuating circumstances that have a policy identifying those the loss or damage of y's responsibility and may not the loss or damage of in accordance with facility ty's responsibility; and assist residents who are participate to apply for ental services as an incurred	F 7	The statements made on this correction are not an admission ot constitute an agreement walleged deficiencies.  To remain in compliance with a regulations the facility has take take the actions set forth in this	n to and do ith the all federal en or will		
	Review of the dental #20 had last seen a Review of Resident a data set assessment	thritis. records revealed Resident		correction. The plan of correctic constitutes the facility's allegat compliance such that all allegat deficiencies cited have been of corrected by the dates indicated.  1. Plan for correcting specific of the plan for corrections are plan for correcting specific of the plan for corrections are plan for corrections.	ion ion of ed r will be ed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345404	B. WING			C <b>12/05/2017</b>	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	<b>I</b>	12/03/2017		
				1403 CONNER DRIVE	_		
THREE RI	VERS HEALTH AND RE	HAB		WINDSOR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 791	Continued From page	e 40	F 79	11			
		ssessed to have an obvious		The process that led to defici	iency cited.		
	11/28/17 revealed Replanned for oral and risk for further decline to coordinate arrange	dental health problems with e. The interventions included ements for dental care and		The facility failed to offer rout services for 1 of 2 residents redental status.  The Resident identified during the facility failed to offer rout services for 1 of 2 residents route.	reviewed for g the survey		
	transportation as nee	eded or as ordered. n 11/28/17 at 2:42 PM		was discharged from the faci 12-20-2017.	lity on		
		served to have broken lower		Resident interviews will be co offer each Resident dental se Residents that agree will hav	ervices. All		
	_	on 12/01/17 at 10:56 AM anager #1 stated she was heduled dental		appointment made and then appointments made thereafte Resident that decline dental s	er. Any		
	and they are schedul routine dental care. S	wn local dentists in the area ed yearly through them for She further stated that		have responses documented medical record. 12-31-201	7		
	2016. She further sta Responsible Party ha	e dentist in November of ted that Resident #20's ad signed a consent for care h included dental care and		The procedure for implement acceptable plan of correction specific deficiency cited: -	•		
	Resident #20. She fu was not currently sch appointments. She fu reason that the facilit	tine dental services for arther stated Resident #20 neduled for any dental arther stated there was no by had not arranged for the autine dental exam and		On 12-12-17,The Administration of Nursing, began in servicing and PRN RN's, LPN's, and Discount of Managers on the following process.	g all FT, PT, Department		
	and had not been see year.	ne dental exam was missed en by a dentist in over a on 12/1/17 at 11:31 AM the		The staff will be in-serviced of and to include the facility must obtain from an outside resou dental services and emergen services to the meet the need	st provide or rce routine acy dental		
	Administrator stated either a consultant de	that residents are seen by entist or a dentist of choice.		resident	uo oi odoii		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345404	B. WING			1	05/2017	
NAME OF PROVIDER OR SUPPLIER  THREE RIVERS HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE  1403 CONNER DRIVE  WINDSOR, NC 27983			05/2017	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG				(X5) COMPLETION DATE	
F 791	was only offered on a routine annual dental  During an interview o Consultant #1 stated all residents annual rebecause nursing staff	eeded. She further stated it in as needed based and care was not offered.  In 12/1/17 at 11:34 AM Nurse that the facility did not offer outine dental services if provided the quarterly and the resident's oral health.	F	791	Any in-house staff member who did not receive in-service training by 12-31-20 will not be allowed to work until training has been completed. This information in been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained.  The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements:  The Director of Nursing, MDS Coordinator, Admission Coordinator, Social Services Assistant and or Health Information Manager will conduct audit ensure Residents are being provided routine dental services. The audits will conducted weekly for two weeks and monthly for 3 months. This monitoring continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure correct action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manage.	17 ghas has at at at be will o tive		

	IDENTIFICATION NUMBER.		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345404	B. WING		C
NAME OF PROVIDER OR CURRULER			CTREET ADDRESS CITY STATE ZID CODE	12/05/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THREE RIVERS HEALTH AND REHAB			1403 CONNER DRIVE	
			WINDSOR, NC 27983	
PREFIX (EACH DEFICIENCY MUST BE	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL F		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 791 Continued From page 42		F 79	The title of the person responsible for implementing the plan of correction.  The Administrator is responsible for implementation and completion of the acceptable plan of correction.	