PRINTED: 04/25/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345534	B. WING		C 03/15/2018
	ROVIDER OR SUPPLIER  DHEALTH & REHABILIT	ATION CO	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1702 FARRELL ROAD SANFORD, NC 27330	33.10.23.13
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 000	INITIAL COMMENTS	3	F 000		
		int survey was conducted 03/15/18. Immediate			
	(J)	689 at a scope and severity 600 at a scope and severity			
	The tags F 689 and I Substandard Quality				
F 600 SS=J	Free from Abuse and	was removed on 3/12/18. I Neglect	F 600		3/22/18
	Exploitation The resident has the neglect, misappropria and exploitation as d includes but is not lin corporal punishment	right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from , involuntary seclusion and nical restraint not required to nedical symptoms.			
	§483.12(a) The facili	ty must-			
	physical abuse, corp involuntary seclusion This REQUIREMEN by:	•		Resident #1 reported leg pain to Nurse	
	facility staff, the facili	ty neglected to use 2 staff		#1 on 3/7/18 at approximately 3:35 pm	
APODATORY	DIDECTOR'S OF PROVIDED	SUPPLIER REPRESENTATIVE'S SIGNATU	DE	TITI F	(X6) DATE

04/03/2018 **Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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· · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345534	B. WING _			03	/15/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CANEODE	NUEALTH & DEMARKET	ATION CO		27	702 FARRELL ROAD			
SANFURL	HEALTH & REHABILIT	ATION CO		S	ANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600		e 1 incontinence to Resident #1, sustained by Resident #1 to	F 6	600	Nurse #1 contacted physician with new orders for increased Neurontin on 3/7/			
	the nurse or any othe moved the resident, assessed for serious	er staff. The staff member			at 6pm. The RP was notified on 3/7/18 complaint of pain and new order. The Resident reported relief with new order on 3/7/18. The Resident reported on			
	assistance of two pe risk for more injuries treatment of a fractur	rsons) putting the resident at This resulted in delay in red left femur and pain for			3/8/18 that Neurontin continued to be effective for leg pain. Resident reporter increased leg pain to Nurse #2 on 3/10	)/18		
	reviewed for neglect.				at approximately 3:00 pm. Assessmer by Nurse #2 indicated increased pain upon palpation. The Physician was			
	nurse aide (NA) #1 fa by Resident #1 to the	began on 3/07/18 when ailed to report a fall sustained e nurse or any other staff			notified by Nurse #2 with orders for an x-ray. The X-ray was obtained on 3/10 at 4:30 pm and indicated a left femur	)/18		
	floor to the bed using resident at risk for m	resident by herself from the g a mechanical lift, putting the ore injuries. This resulted in			fracture. The Physician was notified of results by Nurse #2 on 3/10/18 at approximately 5:00pm with new orders	s to		
	to her leg from 3/07/jeopardy was remove	a fractured femur and pain 18 to 3/10/18. Immediate ed on 3/12/18. The facility			send resident to Central Carolina Hosp for direct admission. The RP was notifi by Nurse #2 on 3/10/18 at approximate	ied		
	severity of "D"" (no ha	liance at a lower scope and arm with the potential for ard that is not immediate			5:00pm.  The Resident denied any			
	1	e staff education and ensure out into place are effective.			accidents/injuries when assessed by Nurse #2 on 3/10/18; however, resider roommate reported that during care, a	nt⊡s		
	Findings included:				CNA rolled Resident #1 off bed and on floor. Resident #1 was coded as	to		
	with the current diag	nitted to the facility on 6/2/14 nosis of diabetes, peripheral weakness, and hemiplegia.			moderately cognitively impaired, was usually understood, and always understood others per the MDS assessment of 1/3/18. The roommate			
	(MDS) dated 1/3/18 cognition was moder	erly Minimum Data Set revealed Resident's #1 ately impaired. The resident moods. Resident #1 was			was assessed as cognitively intact, wa always understood, and always understood others per the MDS assessment of 12/28/17. The roomma			
	totally dependent on	staff for bed mobility and			was interviewed on 3/11/18 by the Dire			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING			1	C (4.5/204.8	
NAME OF P	ROVIDER OR SUPPLIER	3.555.		STI	REET ADDRESS, CITY, STATE, ZIP CODE	03/	/15/2018	
NAME OF T	NOVIDEN ON 3011 LIEN				, , ,			
SANFORE	HEALTH & REHAB	LITATION CO			02 FARRELL ROAD			
				SA	ANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 600	Continued From p	page 2	F 6	500				
	The resident also	was totally dependent on staff			confided in any staff that Resident #1	was		
		dressing, toilet use and personal			rolled onto the floor on 3/7/18.			
	hygiene and supe							
	was not steady w			The event occurred as a staff member	did			
		ent on 1 side of her upper			not follow facility procedures for follow			
		one side of her lower extremity.			the care guide for turning and	9		
		always incontinent of bowel and			repositioning, did not follow facility			
	bladder.			procedures for use of a mechanical lift				
					and did not follow facility procedures for	or		
	Review of Reside	nt #1's current care guide			reporting accidents/incidents. CNA #1			
	(which are located	d in the resident's closet) dated			reported during an interview on 3/11/1	8		
	2/22/18 revealed			and 3/12/18 that she was aware of her	ŗ			
	people for assista	nce with turning, repositioning,			requirements to report accidents and			
	and incontinence	care.			injuries, follow the care guide, and did	not		
					ask for assistance although assistance			
		dication Administration Record			was available. Resident #1 □s care gu	de		
	1 '	18 revealed the resident			indicated that the resident required			
		ase dose of 400 milligrams			2-person assistance with turning,			
		on 3/7/18 at 9:00 PM; 3/8/18 at			repositioning, and incontinent care. Cl			
		I and 9:00 PM; 3/9/18 at 9:00			#1 reported during the interview that s			
		9:00 PM and on 3/10/18 at 9:00			was in a hurry to complete her last rou			
	AM and 1:00 PM.				and did not ask for help as she felt she			
	Th	and an the MAD was all of the			could care for the resident alone. CNA			
		nent on the MAR revealed the			stated in the interview that she was av	/are		
		el was a 3 on 3/8/18 at 9:00			of her responsibility to report but	1.4		
	AM.				neglected to do so without reason. CN #1 was aware that failure to report an	A		
	A nursing note do	ted 3/7/18 written by Nurse #1			incident is considered neglect as per			
	_	ent #1 complained of increased			education and in-servicing providing			
		hift and the physician was			throughout her employment.			
	·	ceived a new order to increase			throughout her employment.			
		a medication given for			CNA #1 informed the DON on 3/11/18	at		
		dosage and to administer three			approximately 11:30am that while			
	times a day.	accago and to daminiotor unoc			providing care on the morning of 3/7/1	8		
					that she accidently rolled Resident #1			
	A nursing note da	ted 3/10/18 written by nurse #6			of the bed and onto floor. CNA reporte			
	_	t #1 complained of pain to the			that she was aware that care path			
		lered out in pain when palpated.			indicated resident requires 2-person			
	The physician wa			assistance, but she was in a hurry and	i			

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		345534	B. WING _			C 03/15/2018		
NAME OF P	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	,		
				27	02 FARRELL ROAD			
SANFORD	HEALTH & REHABILIT	ATION CO		SA	ANFORD, NC 27330			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 600	- Figure 1		F 6	500				
	X-RAY was ordered.	The X-RAY result showed a			failed to illicit assistance. CNA #1 repo	rted		
	displaced spiral fract	isplaced spiral fracture of the proximal femur.			that after Resident #1 was on the floor,			
		otified and the resident was			working alone, she utilized a mechanic			
	•	Resident #1 left the facility			lift to transfer resident from floor to bed			
	via Emergency Medi	cal Services at 6:00 PM.			CNA #1 stated that she was aware of			
	A				reporting requirements, but failed to re	port		
		o incident time or date) but			the incident to anyone. CNA#1 was			
		3 under notification. The			removed from the schedule on 3/11/18			
incident report stated that Resident #1 had a fall/injury and the resident had a fracture. After				The Police were contacted by the Direct of Nursing, on 3/11/18 at 7:29pm. A	JUI			
					24-hour report for neglect was submitted	ha		
	complaint of increased left leg pain and a nursing assessment, an X-RAY was ordered and				by the Director of Nursing on 3/11/18 a			
	•	fracture. The Resident			8:35pm.			
	denied accident/injur				о.оории.			
		#2) reported that NA #1			The resident left the facility with EMS of	n		
	·	f of the bed and onto the			3/10/18 at approximately 5pm in transf			
	floor while performing	g care on the morning of			to the hospital.			
	3/7/18. The left femu	r X-RAY revealed a						
	displaced spiral fract	ure of the proximal femur.			A 100% skin assessment of all residen	ts		
		formed and the resident was			was completed by the Director of Nursi	ng,		
		n 3/10/18. The incident			and staff nurses on 3/11/18 including			
	report also revealed				assessment of ROM, bruising, swelling			
	reported to the state	on 3/11/18 at 8:35 PM.			and signs/symptoms of pain. During the	ie		
	Decision of Decision 4	441- 11			assessments, the Director of Nursing			
		#1's Hospital records dated			questioned the alert and oriented			
		t the resident was admitted igh pain and was noted to			residents if they have had any pain, accidents, falls or issues with feeling the	AV.		
	•	roximal, spiral, displaced			have been neglected. No concerns we	-		
		There were no reports from			identified.	16		
		trauma. The resident's			identified.			
		and she was admitted to the			An in-service was initiated on 3/11/18 b	ov		
		r profound anemia and			the Staff Development Coordinator to	- ,		
		od transfusions. Orthopedics			include all staff regarding reporting of			
	were consulted, and on assessment, showed that				incidents/accidents and abuse/neglect			
		ble to move her left lower			immediately to the Charge Nurse. The			
	extremity.				in-service included that lack of providing			
	•				care to a resident per the care plan is			
	NA #1 (who worked v	with Resident #1 during the			considered neglect and included the			
	night shift of 3/6/18 a	nd the early morning on			definition of neglect. This in-service			

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			A. BOILDII	•-		، ا	C		
		345534	B. WING _				15/2018		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
				27	702 FARRELL ROAD				
SANFORD	HEALTH & REHABILIT	TATION CO		s	ANFORD, NC 27330				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE		
F 600	Continued From pag	ge 4	F 6	600					
		wed on 3/13/18 at 12:59 PM.			included instruction on not moving a				
	•	ent #1 was in the bed most of			resident after a fall due to danger of				
		1 was alert and oriented. NA			causing further injury until assessed by	а			
	#1 stated on 03/07/1	18, Resident #1 was			nurse. All employees receive education				
		went to change her. During			hire and annually that indicates that it is				
	the provision of care	e, Resident #1 rolled off the			safe to report accidents/injuries without	1			
	left side of the bed of	onto the floor. NA #1 stated			fear of disciplinary action. No staff will				
		lesident #1 by herself and she			work beyond 3/11/18 until they have				
	•	n rolling off the bed by			received the in-service. Newly hired st	aff			
			will receive the in-service during						
		ped, she left the resident's			orientation.				
	_	hanical lift. NA #1 stated that				1:4			
		ture in the resident's room			Utilizing a Progress Note Review QI Au	ait			
		t #1 back in the bed with the stated that the resident			Tool, the Unit Managers x 2 and/or Weekend Supervisor will review progre	.00			
		ne let the nurse know the			notes daily x 2 weeks, then twice week				
		. NA #1 stated she did not			2 weeks, then weekly x 4 weeks, then	'''			
		hat Resident #1 fell from her			monthly x 1 month to identify any resid	ent			
	-	nd she knew it was wrong, but			complaints of pain to assure a full				
		se her job. NA #1 stated that			assessment had been documented.				
	she did not report th	e incident to anyone. NA #1			Utilizing a Resident Interview for Negle	ct			
		oposed to have 2 people to			QI Audit Tool, the Social Worker will				
		providing care to Resident #1			interview 5 alert and oriented residents				
	•	could not get 2 people to help			weekly x 8 weeks, then 5 residents	_			
		d not help sometimes so they			monthly x 1 month to ensure no neglec				
	had to use only 1 pe	erson.			care had occurred. Utilizing a Pain Auc	it			
	N	North annual college Desident			tool,the Unit Managers x 2 and/or				
	•	2 (who worked with Resident M to 3:00 PM shift on 3/7/18,			Weekend Supervisor will review progre notes daily x 2 weeks, then twice week				
	_	3/10/18) was interviewed on			2 weeks, then weekly x 4 weeks, then	ly X			
		I. NA #2 stated Resident #1			monthly x 1 month to identify any				
		ed. The resident would be			nonverbal resident □s with complaints of	of			
		but would get up occasionally.			pain to assure a full assessment has be				
	_	rred via the mechanical lift			documented.				
		of 2 people. She stated							
		d 2 people to be turned in bed			The Director of Nursing will review the	QI			
	but sometimes she just did it herself. She stated				Audit Tools weekly x 8, then monthly x				
		ring Resident #1 a bed bath			for trends and concerns.				
and the Resident complained of pain in her leg									

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDII	<b>1</b> 0_		,	С	
		345534	B. WING_				15/2018	
	ROVIDER OR SUPPLIER  DHEALTH & REHABILIT	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE  2702 FARRELL ROAD  SANFORD, NC 27330				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Resident's roommate something happened Resident #1 told Resident happened but that he she told nurse #1 an up. Resident #2 neven happened and could Resident #1 then been to want to get up. Resident #1 then been to want to get up. Resident #1 then been to see if it would help resident her lunch transident #1 fell aslet However, on Saturda Resident #1 her lunch confused and started stated that she and National Resident #1 kesident #1 Resident #2 like son Nurse #1 came in to touched her leg and #2 stated that the Refigence #2 then stated that was changing the resident #1 (who works 3/7/18 and 3/8/18 dushift was interviewed stated Resident #1 would make her need to some the some the sident #1 would make her need to some the so	NA #2 stated that the e (Resident #2) stated that d to Resident #1 and sident #2 to "mind her #1 stated that nothing er leg hurt. She stated that d she didn't get the resident er said exactly what be confused at times. came very drowsy and did tesident #1 also stated that wer she asked her. NA #2 ent #1 up one time that week by, 3/7/18 or Thursday resident stated she wanted o with the pain. She gave the ay and it was usual that ep when she gave her meal.	F	600	The Administrator will report the results the monitoring to the Quality Assurance Committee monthly x 3 months for trer concerns, and recommendations for an modification of the process.  The Administrator will be responsible for implementing the plan of correction.	e nds, ny		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345534	B. WING		,	C 03/15/2018	
	ROVIDER OR SUPPLIER  HEALTH & REHABILIT.			STREET ADDRESS, CITY, STATE, ZIP COD 2702 FARRELL ROAD SANFORD, NC 27330		3713/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF  REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION DATE	
F 600	for bed mobility. Nurs morning of 03/07/18, Resident #1 was hav stated that Resident in her leg but could in pain. The Resident is burning and she gave medication for pain. She stated that she leand that she was able adjust it and it was of Resident. Nurse #1 stated that medication resident the medication Resident was having was why she got the increased. Nurse #1 any reports from the Resident #1 falling.  Attempts were made worked with Resident to 7:00 AM, but Nurs for an interview.  NA #4 (who worked worked with Resident #1 stated that Resident #4 stated that Resident #4 stated that Resident #4 stated that Resident #1 would not to the part of the Resident #1 would not the part of the part of the part of the Resident #1 would not the part of the part	f 2 people to get up. 2 people for transfers and se #1 stated during the the NA informed her that ing some pain. Nurse #1 #1 was complaining of pain of pinpoint the location of the tated that the pain was e the resident some She stated the Resident was out it was not red or swollen. booked at the Resident's leg e to move the Resident's leg, k but it just hurt per the stated she contacted the n orders for Neurontin to be nes a day and she gave the on. She thought the possible nerve pain, which Neurontin medication stated that she did not get	F 60				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345534	B. WING _			C <b>03/15/2018</b>	
	ROVIDER OR SUPPLIER  HEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		03/13/2010	
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F 600	Continued From page 7 them change her, but was having pain in her leg		F 6	00			
	•	over so she adjusted how e resident seemed fine.					
	3rd shift on 3/7/18 at 3/13/18 at 2:43 PM. incontinent and she by herself but technihave 2 people. NA # Resident #1 by herset the resident. NA #5 susually alert and ories something was wron she turned Resident her legs over with a said it hurt so she turned the	with Resident #1 during the nd 3/9/18) was interviewed on She stated the resident was usually changed the resident cally they were supposed to 5 stated that she changed elf because she was used to stated that Resident #1 was ented and would tell staff if ng. She stated that recently #1 on the right side, crossed little push and the resident rined the Resident on the right the Resident was the turned her the other way med ok the other side.					
	She stated that Resiget her up and need usually alert and ories #2 asked her to come care of Resident #1 the resident if she was rubbing her leg. the Resident if she hot respond. NA #8 the resident started if Roommate (Resident resident had fallen. Tassessed Resident # having pain when the	ewed on 3/13/18 at 3:54 PM. dent #1 needed 2 people to ed the lift. The Resident was ented. NA #8 stated that NA e in the room to help with the on 3/10/18 and she asked as having pain. The resident She stated she also asked and a fall and the resident did went to turn Resident #1 and hollering. The Resident's at #2) then told them that the The nurse came in and #1 and the resident was e nurse touched the area on d she stayed with the resident					

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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	interviewed on 3/13/stated that on 03/07/when she heard Res Resident #2 specifie care to Resident #1 Ifell out of bed. She shetween the evening #2 stated the staff mafter the fall occurred observed the NA pustresident after she fell herself and put the restated Resident #1 wwas moved. Resident 3 or 4 days later when hospital. Resident #2 was right across the but the NA never got fell.  Attempts were made worked on 3/10/18 fr Resident #1) for an incontacted.  The Administrator was 4:25 PM. She stated Resident #1's first fa same NA (NA #1) ind with care they determineded 2 person assincluded for the staff the resident's closet assistance. An incided 3/10/18 about Resided did not find out about 03/07/18 until 3/10/1	rred to the hospital. mate (Resident #2) was 18 at 12:50 PM. Resident #2 18 she was in her room ident #1 fall out of bed. d that NA #1 was providing by herself when the resident tated the fall occurred and early morning. Resident ember did not get the nurse d. Resident #2 stated she the lift pad under the land use the lift to lift by esident back in the bed. She would holler every time she at #2 stated that it was about an Resident #1 went to the further stated that the nurse hall when Resident #1 fell, the nurse after the resident  to contact Nurse #6 (who om 7:00 AM to 7:00 PM with interview but she could not be as interviewed on 3/13/18 at that on 12/15/17, when the li from bed occurred with the dependently assisting her nined all residents who sistance with care. Education to follow the care guides in	F 60				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345534	B. WING _			C 03/15/2018	
	ROVIDER OR SUPPLIER  HEALTH & REHABILI	TATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330	'	36.16.2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
F 600	stated "aren't you go rolling them out of b about the resident's report from the room staff when the reside pain, which was on interviewing all staff dropped out of the b questioned and this able to get in contact that she rolled Resident she did not report admitted to her that laying on her left and member providing contacted the mechanical lift to the bed with no assistated she contacted the state of turned over the inverse called the offic having increased pandrse thought it was an increase in her No could not recall the ending pain in the left of the state of the sta	#1's roommate spoke up and bing to tell them about you ed". When they found out fracture and since they had a mate, they started contacting ent started complaining of	F 6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		(X3) DATE SURVEY COMPLETED		
			A. BOILDI			(	c
		345534	B. WING			1	15/2018
	ROVIDER OR SUPPLIER  DHEALTH & REHABILI	TATION CO	•	270	REET ADDRESS, CITY, STATE, ZIP CODE 02 FARRELL ROAD ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO			(X5) COMPLETION DATE
F 600	the resident was hy Hemoglobin was 4. hemorrhagic shock had surgery yet at t further stated that F anticoagulation their bleeding into her leprobably had a histithe Resident had no before that he could asked the resident him that she fell out stated that she didn' NA #1 was interview PM. NA #1 stated the experienced on 03/AM to 6:00 AM. NA left side and she tol Resident was rolled bed.  Nurse #1 was interview would assess the rette fall to the family an incident report.  NA # 4 stated on 3/would report it to the abused or had a fall The Administrator was or involved abuse or neglect.  The Administrator was Jeopardy on 3/14/1 1:41 PM, the facility	ident #1 got to the hospital, pothermic and her 3. The Resident was close to and the Resident still has not he hospital. The Physician Resident #1 was on rapy and was probably g. He thought the resident ory of osteoporosis and stated of had a fracture or break d think of. He stated that he that happened and she told to foed the other night and off tell the nurse. Wed again on 3/14/18 at 2:51 that the fall Resident #1 07/18 occurred at around 5:30 #1 stated the resident on her d the resident to roll. The laway from her and off of the viewed again on 3/14/18 at d that if a resident fell she esident, call the doctor, report and supervisors and fill out 14/18 at 3:11 PM that she en urse if a resident was	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245524	B. WING			С	
NAME OF D		345534	B. WING _	OTDEET ADDRESS SITV STATE 7/D SODE		03/15/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SANFORE	HEALTH & REHABILIT	ATION CO		2702 FARRELL ROAD SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRI		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 600	Continued From pag	e 11	F 6	500			
	3/7/18 at approximate contacted physician vincreased Neurontin was notified on 3/7/1 new order. The Resident orders on 3/7/18. The 3/8/18 that Neurontin leg pain. Resident re Nurse #2 on 3/10/18. Assessment by Nurse pain upon palpation. by Nurse #2 with orders on 3/10 indicated a left femural notified of results by approximately 5:00president to the hospit RP was notified by Napproximately 5:00president to the hospit RP was notified by Napproximately 5:00president denied assessed by Nurse #resident's roommate CNA (nurse aide) roll onto floor. Resident cognitively impaired, always understood of assessment of 1/3/18 assessed as cognitively understood, and always the MDS assessment roommate was intervolled in any staff onto the floor on 3/7/1 The event occurred as	on 3/7/18 at 6pm. The RP 8 of complaint of pain and dent reported relief with new e Resident reported on continued to be effective for ported increased leg pain to at approximately 3:00 pm. e #2 indicated increased The Physician was notified ers for an x-ray. The X-ray 0/18 at 4:30 pm and fracture. The Physician was Nurse #2 on 3/10/18 at m with new orders to send al for direct admission. The urse #2 on 3/10/18 at m.  any accidents/injuries when 2 on 3/10/18; however, reported that during care, a ed Resident #1 off bed and #1 was coded as moderately was usually understood, and thers per the MDS 3. The roommate was ely intact, was always ays understood others per t of 12/28/17. The iewed on 3/11/18 by the and reported she had not that Resident #1 was rolled					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			74. 50.25			، ا	2
		345534	B. WING			1	15/2018
NAME OF P	ROVIDER OR SUPPLIER	0.0001			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	15/2016
TO THE OT THE	NOVIDER OR COLL FIER				2702 FARRELL ROAD		
SANFORE	HEALTH & REHABILITA	ATION CO			SANFORD, NC 27330		
			1				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	facility procedures for and did not follow factorized accidents/incidents. (interview on 3/11/18 requirements to report follow the care guide, assistance although a Resident #1's care guident required 2-port follow factorized accident factorized factori	repositioning, did not follow r use of a mechanical lift, sility procedures for reporting CNA #1 reported during an that she was aware of her rt accidents and injuries, and did not ask for assistance was available. Lide indicated that the erson assistance with	F	600			
	#1 reported during the hurry to complete her for help as she felt shalone. CNA #1 stated was aware of her resenglected to do so with aware that failure to reconsidered neglect as in-servicing providing employment. CNA #1 informed the	s per education and throughout her					
	on the morning of 3/7 rolled Resident #1 ou CNA reported that shindicated resident recount she was in a hurr assistance. CNA #1 r #1 was on the floor, we mechanical lift to transided. CNA #1 stated to reporting requiremen incident to anyone. Conscient to anyone conscient to anyone conscient to anyone conscient to anyone conscient to anyone. Conscient to anyone conscient	7/18 that she accidentally at of the bed and onto floor. He was aware that care path equires 2-person assistance, by and failed to illicit reported that after Resident evorking alone, she utilized a disfer resident from floor to that she was aware of the she was aware of the expert the expert of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  3		ATE SURVEY OMPLETED
		345534	B. WING			C 03/15/2018
	ROVIDER OR SUPPLIER  HEALTH & REHABILIT	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE  2702 FARRELL ROAD  SANFORD, NC 27330		00/10/2010
(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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 600	2. A 100% skin ass completed by the Dir nurses on 3/11/18 in bruising, swelling, ar During the assessme questioned the alert have had any pain, a feeling they have betwere identified.  An in-service was into Development Coording reporting of abuse/neglect immediates abuse/neglect immediates are sident after a fall further injury until as employees receive annually that indicate accidents/injuries with action. No staff will whave received the interest and included a resident significant and semployees received annually that indicate accidents/injuries with action. No staff will whave received the interest and included a resident significant and semployees received the interest and included accidents/injuries with action. No staff will whave received the interest and included accidents/injuries with action.	in in transfer to the hospital. It is sessment of all residents was sector of Nursing, and staff cluding assessment of ROM, and signs/symptoms of pain. It is the Director of Nursing and oriented residents if they accidents, falls or issues with the neglected. No concerns that do not include all staff of incidents/accidents and diately to the Charge Nurse. The definition of neglect. The definition of neglect. The definition of neglect. The definition on not moving due to danger of causing sessed by a nurse. All ducation on hire and the staff of the staff of the service. Newly hired staff	F 6	,		
	3. Utilizing a Progr Tool, the Unit Manag notes daily to identify pain to assure a full documented. The W review progress note identify any resident a full assessment ha Utilizing a Resident I Tool, the Social Worl oriented residents w	ess Note Review QI Audit ers x 2 will review progress of any resident complaints of assessment had been deekend Supervisor will es each weekend daily to complaints of pain to assure d been documented. Interview for Neglect QI Audit ever will interview 5 alert and evekly to ensure no neglect of Jtilizing a Pain Audit tool, the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		345534	B. WING _			C 03/15/2018
	ROVIDER OR SUPPLIER  D HEALTH & REHABILIT.	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		33,13,2310
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	Unit Managers x 2 w daily to identify any n complaints of pain to has been documented through Friday x 2 well then monthly x 1 mon The Director of Nursi Tools weekly x 8, the concerns.  4. The Administrate monitoring to the Quamonthly x 3 months for recommendations for process.  The Administrator will implementing this creating the credible allegation 3:30 PM as evidence and non-licensed state when and how to represent and when and how to represent and when and the procedure for abuse. Note that the procedure for abuse along with other abuse reported. Record revaudit tool was completed tool 3/11/18. As started on 3/11/18.	ill review progress notes converbal resident's with assure a full assessment ed. Audits will occur Monday eeks, Weekends x 2, then ks, then weekly x 4 weeks, onth.  Ing will review the QI Audit on monthly x 1 for trends and for will report the results of the eality Assurance Committee for trends, concerns, and or any modification of the eality assurance of the eality Assurance Committee for trends, concerns, and or any modification of the eality assurance Committee for trends, concerns, and or any modification of the eality assurance Committee for trends, concerns, and or any modification of the eality assurance Committee for trends, concerns, and or any modification of the eality assurance Committee for trends, concerns, and or any modification of the eality assurance Committee for the ality assurance Committee for trends, concerns, and or any modification of the eality assurance Committee for trends, concerns, and or any modification of the eality assurance Committee for trends and enditive trends of the eality assurance Committee for the eality assurance Committee for trends and enditive trends of the eality assurance Committee for trends and enditive for the eality assurance Committee for the eality assurance Committee for the eality assurance Committee for trends and enditive for the eality assurance Committee for the e	F 6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345534	B. WING			C 03/15/2018
NAME OF PE	ROVIDER OR SUPPLIER	0.0001		STREET ADDRESS, CITY, STATE, ZIP CODE		03/15/2016
TO UNIC OF TH	TO VIDER ON OUT FEILER			2702 FARRELL ROAD		
SANFORD	HEALTH & REHABILITA	ATION CO		SANFORD, NC 27330		
0411.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES				0/5)
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	Continued From page	e 15	F 68	39		
F 689	Free of Accident Haz	ards/Supervision/Devices	F 68	39		3/22/18
SS=J	CFR(s): 483.25(d)(1)					
	§483.25(d) Accidents The facility must ensu					
		sident environment remains				
	. , , ,	zards as is possible; and				
	§483.25(d)(2)Each re	sident receives adequate				
		stance devices to prevent				
	accidents.	•				
	This REQUIREMENT	is not met as evidenced				
	by:					
	Based on record revi	ew and interviews with the		Resident #1 reported leg pain t	o Nurse	
	staff, family, and the	ohysician the facility failed to		#1 on 3/7/18 at approximately 3	3:35 pm.	
		e of two staff members		Nurse #1 contacted physician w		
		of incontinence care to		orders for increased Neurontin		
		m falling from bed and		at 6pm. The RP was notified or		
		or 1 of 3 residents sampled		c/o of pain and new order. The		
		s (Resident #1). Resident		reported relief with new orders		
		hen only one nurse aide		The Resident reported on 3/8/1		
		h incontinence care and she		Neurontin continued to be effect	•	
	sustained a fractured			pain. Resident reported increas		
		esident, alone, before being injury, from the floor to the		to Nurse #2 on 3/10/18 at appro	•	
		cal lift (resident required the		3:00 pm. Assessment by Nurse indicated increased pain upon p		
	<u> </u>	sons) putting the resident at		The Physician was notified by N	•	
	·	This resulted in delay in		with orders for an x-ray. The X-		
		ed left femur and pain for		obtained on 3/10/18 at 4:30 pm		
	three days.	ed left femal and pain for		indicated a left femur fracture.		
				Physician was notified of results		
	Immediate ieopardy b	pegan on 3/07/18 when		#2 on 3/10/18 at approximately		
		illed to report a fall sustained		with new orders to send resider		
		nurse or any other staff		Central Carolina Hospital for dir		
	_	esident by herself from the		admission. The RP was notified	d by	
		a mechanical lift, before		Nurse #2 on 3/10/18 at approxi	mately	
	being assessed for in	jury putting the resident at		5:00pm.	-	
	risk for more injuries.	This resulted in delay of				
	treatment of a fracture	ed femur and pain to her leg		The Resident denied any		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION		DATE SURVEY COMPLETED	
				_		(		
		345534	B. WING			1	15/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				2	702 FARRELL ROAD			
SANFORL	HEALTH & REHABILITA	ATION CO		s	ANFORD, NC 27330			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 689	Continued From page	e 16	F	689				
	from 3/07/18 to 3/10/	18. Immediate jeopardy was			accidents/injuries when assessed by			
		The facility remains out of			Nurse #2 on 3/10/18; however, residen	t⊡s		
		r scope and severity of "D'"			roommate reported that during care, a			
		ential for more than minimal			CNA rolled Resident #1 off bed and on	to		
	•	diate jeopardy) to complete			floor. Resident #1 was coded as			
	staff education and er	nsure monitoring systems			moderately cognitively impaired, was			
	put into place are effe	ective.			usually understood, and always			
					understood others per the MDS			
	Findings included:				assessment of 1/3/18. The roommate			
		nitted to the facility on 6/2/14			was assessed as cognitively intact, was	S		
		osis of diabetes, peripheral			always understood, and always			
	neuropathy, muscle w	veakness, and hemiplegia.			understood others per the MDS			
					assessment of 12/28/17. The roomma			
	-	ted 12/15/17 stated Resident			was interviewed on 3/11/18 by the Dire	ctor		
	_	ontinent care by nursing			of Nursing and reported she had not			
		e Resident was on her left			confided in any staff that Resident #1 v rolled onto the floor on 3/7/18.	vas		
		s cleaning the resident. The			Tolled office the floor off 5/7/16.			
	Resident reached out	as to grap onto the noto			The event occurred as a staff member	did		
	_	was assessed and put			not follow facility procedures for following			
	back to bed. Vital sign				the care guide for turning and	19		
	_	en stated that Resident #1			repositioning, did not follow facility			
		e of 2 people to change her			procedures for use of a mechanical lift,			
	and for perineal care.				and did not follow facility procedures fo			
					reporting accidents/incidents. CNA #1			
	Review of Resident's	#1 Quarterly Minimum Data			reported during an interview on 3/11/18	3		
		18 revealed her cognition			and 3/12/18 that she was aware of her			
		ired. The Resident had no			requirements to report accidents and			
	behaviors or moods.	Resident #1 required total			injuries, follow the care guide, and did			
		mobility and transfers and			ask for assistance, although assistance			
		ce of 2 people. The Resident			was available. Resident #1□s care gui	de		
		pendence with locomotion,			indicated that the resident required			
	_	nd personal hygiene and			two-person assistance with turning,			
		g. Resident #1 was not			repositioning, and incontinent care. CN			
	•	surface transfers and had			#1 reported during the interview that sh			
		of her upper extremity and			was in a hurry to complete her last rour			
		ver extremity. The resident			and did not ask for help as she felt she			
	was always incontine	nt of bowel and bladder.			could care for the resident alone.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	SURVEY
							С
		345534	B. WING _			03/	15/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		1710V 00		27	702 FARRELL ROAD		
SANFORD	HEALTH & REHABILIT	ATION CO		S	ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					52.102.101,		
F 689	recently updated/rev addressed issues ind assistance with activ being at risk falls whi Interventions for falls	t care plan, which was most iewed by staff on 3/14/18,	F	689	CNA #1 informed the DON on 3/11/18 approximately 11:30am that while providing care on the morning of 3/7/18 that she accidently rolled Resident #1 of the bed and onto floor. CNA reported that she was aware that care path indicated resident requires 2-person	3 out	
	the bed as she often	ical lift and repositioned in leans to the right side.	assistance, but she was in a hurry and failed to illicit assistance. CNA #1 reported that after Resident #1 was on the floor, working alone, she utilized a mechanical				
	(which are located in 2/22/18 revealed that	#1's current care guide the resident's closet) dated t the resident required 2 e with turning, repositioning, re.			working alone, she utilized a mechanic lift to transfer resident from floor to bed CNA #1 stated that she was aware of reporting requirements, but failed to repute the incident to anyone. CNA#1 was removed from the schedule on 3/11/18	oort	
	stated that Resident pain to legs this shift contacted and receiv the Gabapentin (a m neuropathic pain) do	3/7/18, written by Nurse #1, #1 complained of increased and the physician was ed a new order to increase edication given for sage and to administer three			The Police were contacted by the Direct of Nursing on 3/11/18 at 7:29pm. A 24-hour report for abuse was submitted by the Director of Nursing on 3/11/18 at 8:35pm.	etor 1	
	#6, revealed Resider	3/10/18, written by Nurse of #1 complained of pain to	The resident left the facility with EMS on 3/10/18 at approximately 5pm in transfer to the hospital.		er		
	palpated. The physic femur X-RAY was or showed a displaced femur. The physician resident was sent to via Emergency Medi	llered out in pain when ian was notified and a left dered. The X-RAY result spiral fracture of the proximal was notified and the the hospital. Resident #1 left cal Services at 6:00 PM.			A 100% skin assessment of all resident was completed by the Director of Nursi and staff nurses on 3/11/18 including assessment of ROM, bruising, swelling and signs/symptoms of pain. During the assessments, the Director of Nursing questioned the alert and oriented residents if they have had any pain,	ng ,	
	had a date of 3/10/18 incident report stated fall/injury and the res	o incident time or date) but B under notification. The I that Resident #1 had a ident had a fracture. After ed left leg pain and a nursing			accidents, or falls. No concerns were identified.  An in-service was initiated on 3/11/18 to the Staff Development Coordinator to	ру	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPL							
		345534	B. WING				C
NAME OF PE	ROVIDER OR SUPPLIER	0.000.	<del>                                     </del>	STR	REET ADDRESS, CITY, STATE, ZIP CODE	03/	15/2018
TVAINE OF T	COVIDENCE ON OUT LIEN						
SANFORD	HEALTH & REHABILITA	ATION CO			2 FARRELL ROAD		
				SA	NFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	e 18	F 6	89			
	assessment, an X-RA	AY was ordered and			include all licensed nurses regarding		
		fracture. The Resident			assessment upon notification of pain		
	denied accident/injuri				including AROM and PROM and		
	-	#2) reported that NA #1			documentation of findings in the		
	rolled the resident off	of the bed and onto the			resident □s progress notes. No license	ed	
	floor while performing	care on the morning of			staff will work beyond 3/11/18 until the	У	
	3/7/18. The left femur	X-RAY revealed a			have received the in-service. Newly hi	red	
	displaced spiral fractu	ure of the proximal femur.			licensed nursing staff will receive the		
	The physician was in	formed and the resident was			in-service during orientation.		
	sent to the hospital or	n 3/10/18.					
					An in-service was initiated on 3/11/18 I	by	
		1's Hospital records dated			the Staff Development Coordinator to		
		the resident was admitted			include all clinical staff including nurse		
	· · · · · · · · · · · · · · · · · · ·	igh pain and was noted to			and certified nursing assistants regard	ing	
	Telephone and the second secon	oximal, spiral, displaced			use of care guide, 2-person assist		
		The resident reported that			requirements, and use of mechanical li		
		d on 3/7/18 and that she			requiring 2-persons. Although staffing		
		ed. There were no reports			not an issues; staff were made aware to		
	_	ity of trauma. The resident's			they can illicit help from any clinical sta	ιπ	
		and she was admitted to the			member. No staff will work beyond		
		r profound anemia and			3/11/18 until they have received the	:11	
		od transfusions. Orthopedics on assessment showed that			in-service. Newly hired nursing staff w		
		ble to move her left lower			receive the in-service during orientation	11.	
	extremity.	ble to move her left lower			An in-service was initiated on 3/11/18 l	hv	
	Oxtronity.				the Staff Development Coordinator to	<b>-</b>	
	NA #1 (who worked v	vith Resident #1 during the			include all staff regarding reporting of		
	•	nd the early morning on			incidents/accidents and abuse/neglect		
		red on 3/13/18 at 12:59 PM.			immediately to the Charge Nurse. This		
	•	nt #1 was in the bed most of			in-service included that is safe to report		
		was alert and oriented. NA			accidents/injuries and included the		
	#1 stated on 03/07/18	3, Resident #1 was			definition of neglect. This in-service		
		vent to change her. During			included instruction on not moving a		
		Resident #1 rolled off the			resident after a fall due to danger of		
		nto the floor. NA #1 stated			causing further injury until assessed by	/ a	
	she was changing Re	esident #1 by herself and she			nurse. No staff will work beyond 3/11/1		
	tried to stop her from	rolling off the bed by			until they have received the in-service.		
	grabbing her arm. Sh	e stated that after the			Newly hired nursing staff will receive th	ne	
	resident fell off the be	ed, she left the resident's			in-service during orientation.		

OL. VILLIV	O I OIT INEDIOTITE OF	. CEITAIGE				<u> </u>	<del>7. 0000 000 1</del>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			7. 50,201			(	С
		345534	B. WING				15/2018
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SANFORD	HEALTH & REHABILITA	ATION CO			702 FARRELL ROAD		
				S	ANFORD, NC 27330		
(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 689	she moved the furnituand placed Resident streported pain and she resident was in pain. report to the nurse the bed onto the floor and she didn't want to lose she did not report the stated they were suphelp with the lift and put sometimes you can the nurses would had to use only 1 personally. The resmechanical lift and the She stated Resident struned in bed but some herself. She stated she resident struned in bed but some herself. She stated she complained of pain in the Resident struned in bed but some that something happer Resident strung happened but that he on 3/10/18, she and Nothing Resident strunging Residen	anical lift. NA #1 stated that are in the resident's room #1 back in the bed with the tated that the resident elet the nurse know the NA #1 stated she did not at Resident #1 fell from her dishe knew it was wrong, but the her job. NA #1 stated that incident to anyone. NA #1 boosed to have 2 people to providing care to Resident #1 build not get 2 people to help anot help sometimes so they son.  A) #2 (who worked with the 7:00 AM to 3:00 PM shift /18, and 3/10/18) was 8 at 12:16 PM. NA #2 stated that and oriented. The resident the bed but would get up ident transferred via the ele assistance of 2 people. #1 required 2 people to be netimes she just did it he was recently giving the and the Resident her leg. NA #2 stated that hate (Resident #2) stated that nothing the stated that nothing religible in the leg hurt. NA #2 stated that Nursing Assistant #3 were I and when they turned the	F	689	Utilizing a QI audit tool, the unit manag x2 will observe 3 incidents of staff operating mechanical lifts Monday thro Friday x 2 weeks, then twice weekly x weeks, then weekly x 4 weeks, then monthly x 1 month to ensure that the resident is being transferred via mechanical lift according to the care guand the resident scare plan. The Weekend Supervisor will observe 3 incidents of staff operating mechanical lifts on weekends x 2 weekends, then every other weekend x 2, then monthly month to ensure that the resident is be transferred via mechanical lift accordin the care guide and the resident scare plan.  Utilizing a QI audit tool, the unit manag x 2 will observe 3 incidents of staff turn and reposition residents Monday throu Friday x 2 weeks, then twice weekly x weeks, then weekly x 4 weeks, then monthly x 1 month to determine if the resident is being turned and reposition in bed according to the resident care guide and care plan. The Weekend Supervisor will observe turning/repositioning on weekends x 2 weekends, then every other weekend x 2 the monthly x 1 month to determine if the resident is being turned and reposition in bed according to the resident care guide and care plan.  Utilizing a Progress Note Review QI Auton, the Unit Managers x 2 will review	ugh 2  uide  x 1 ing g to ers gh 2  ed  x 2, he ed	
	Resident, she started grabbed NA #2 like sl	hollering, crying and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(	
		345534	B. WING _			03/	15/2018
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CANEODE	NUEALTU O DEUADILIT	ATION CO		27	702 FARRELL ROAD		
SANFURL	HEALTH & REHABILIT	ATION CO		S	ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	#2 stated that the Re #2) then stated that e was changing the resher off the bed.  Nurse #1 (who worke 3/7/18 and 3/8/18 dushift was interviewed stated Resident #1 would make her need that Resident #1 requand the assistance of Resident #1 needed for bed mobility. Nursemorning of 03/07/18, Resident #1 was have stated that Resident in her leg but could repain. The Resident sound in the pain. The Resident sound in the stated that she gave medication for pain. also rubbing her leg She stated that she I and that she was able adjust it and it was of Resident. Nurse #1 sedoctor and was given increased to three tir resident the medication Resident was having	the resident yelled out. NA esident's roommate (Resident earlier in the week, NA #1 sident by herself and rolled ed with Resident #1 on ring the 7:00 AM to 7:00 PM on 3/13/18 at 2:15 PM. She was alert and oriented and els known. Nurse #1 specified wired maximum assistance of 2 people for transfers and se #1 stated during the other than the NA informed her that wing some pain. Nurse #1 #1 was complaining of pain not pinpoint the location of the stated that the pain was the tresident some She stated the Resident was but it was not red or swollen. Tooked at the Resident's leg the to move the Resident's leg, the but it just hurt per the stated she contacted the norders for Neurontin to be the sa day and she gave the ion. She thought the possible nerve pain, which	F6	689	resident complaints of pain to assure a assessment had been documented. The Weekend Supervisor will review progres notes each weekend daily to identify an resident complaints of pain to assure a assessment had been documented. Passessments are completed by the charge nurse each shift for all residents including those residents who are nonverbal. Utilizing a Pain Audit tool, the Unit Managers x 2 will review progress notes daily to identify any nonverbal residents with complaints of pain to assure a full assessment has been documented. The Weekend Supervisor will review progress notes each weeked daily to identify any nonverbal residents with complaints of pain to assure a full assessment has been documented. Audits will occur Monday through Fridate 2 weeks, Weekends x 2, then twice weekly x 2 weeks, then weekly x 4 week then monthly x 1 month.  The Director of Nursing will review the Audit Tools weekly x 8, then monthly x for trends and concerns  The Director of Nursing will report the results of the monitoring to the Quality Assurance Committee monthly x 3	he ess ny full ain s, ne r nd s	
	increased. Nurse #1 any reports from the Resident #1 falling.  Attempts were made worked with Residen	Neurontin medication stated that she did not get staff that night about to contact Nurse #5, who it #1 on 3/7/18 from 7:00 PM e #5 could not be contacted			months for trends, concerns, and recommendations for any modification the process.  The Administrator will be responsible for implementing the plan of correction.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C <b>03/15/2018</b>
	ROVIDER OR SUPPLIER  HEALTH & REHABILIT	TATION CO		STREET ADDRESS, CITY, STATE, ZIP C 2702 FARRELL ROAD SANFORD, NC 27330	CODE	03/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 689	from 3:00 PM to 11:0 3/13/18 at 3:57 PM. report that the Resideleg was hurting and usually complain of ptold the nurse that Resident #1 would not hurting. NA #4 stated them change her, but when they rolled her she rolled her and the NA #5 (who worked 3rd shift on 3/7/18 at 3/13/18 at 2:43 PM. incontinent and she by herself but technically alert and ories something was wrong she turned Resident her legs over with a said it hurt so she turnother side. She thou uncomfortable and sand the resident see	with Resident #1 on 3/7/18 00 PM) was interviewed on NA #4 stated she got in ent's leg had been sore. NA ent #1 informed her that her that Resident #1 did not bain. NA #4 stated that she esident #1 was in pain. ot tell her why her leg was d that the Resident would let it was having pain in her leg over so she adjusted how e resident seemed fine.  with Resident #1 during the and 3/9/18) was interviewed on She stated the resident was usually changed the resident cally they were supposed to 5 stated that she changed elf because she was used to stated that Resident #1 was ented and would tell staff if g. She stated that recently #1 on the right side, crossed little push and the resident rined the Resident on the right the Resident was he turned her the other way med ok the other side.	F	689		
	Resident #1 on 3/10. PM shift) was intervious She stated that Residet her up and need	isted NA #2 with the care of /18 during 3:00 PM to 11:00 ewed on 3/13/18 at 3:54 PM. dent #1 needed 2 people to ed the lift. The resident was ented. NA #8 stated that NA				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 03/15/2018
	ROVIDER OR SUPPLIER  D HEALTH & REHABILIT			STREET ADDRESS, CITY, STATE, ZIP COD 2702 FARRELL ROAD SANFORD, NC 27330		33/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 689	care of Resident #10 the resident if she wa was rubbing her leg. the Resident if she h not respond. NA #8 w the resident started h Roommate (Residen resident had fallen. T assessed Resident # having pain when the her leg. NA #8 stated until she was transfe  The resident's roomr interviewed on 3/13/r stated that on 03/07/ when she heard Res Resident #2 specified care to Resident #1 l fell out of bed. She s between the evening #2 stated the staff ma after the fall occurred observed the NA pus resident after she fell herself and put the re stated Resident #1 w was moved. Resident 3 or 4 days later whe hospital. Resident #2 was right across the but the NA never got fell.  Attempts were made worked on 3/10/18 fr	e in the room to help with the on 3/18/18 and she asked as having pain. The resident She stated she also asked ad a fall and the resident did went to turn Resident #1 and collering. The Resident's truly then told them that the the nurse came in and the resident was a nurse touched the area on the stayed with the resident	F 6	89		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345534	B. WING_			C 3/15/2018
	ROVIDER OR SUPPLIER	LITATION CO		STREET ADDRESS, CITY, STATE, ZIP C 2702 FARRELL ROAD SANFORD, NC 27330	•	3/13/2010
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 689	4:25 PM. She star Resident #1's first same NA (NA #1) with care they det needed 2 person included for the st the resident's clos assistance. An ind 3/10/18 about Res	was interviewed on 3/13/18 at ted that on 12/15/17, when the fall from bed occurred with the independently assisting her ermined all residents who assistance with care. Education aff to follow the care guides in tet and use 2 person cident report was put in on sident #1's fall on 3/7/18, so she tout the fall which occurred on	F	589		
	that Resident #1 occurred. Resider stated "aren't you rolling them out of about the resident report from the rostaff when the respain, which was of interviewing all stadropped out of the questioned and the able to get in confidence.	2/18. The administrator stated denied that the incident had at #1's roommate spoke up and going to tell them about you be bed. When they found out the started contacting ident started complaining of a 3/7/18. They started aff about the resident being the bed. On 3/11/18, NA #1 was ais was the first time they were started with her. NA #1 admitted				
	that she did not readmitted to her the laying on her left as member providing resident rolled off the mechanical lift the bed with no as stated she contact contacted the state turned over the in Resident #1's Physical Provides admitted the state of the state over the in the state over the interest of the state over the interest over the state over the interest over the state over the interest over the state ov	sident #1 out of the bed and eport the fall to anyone. NA #1 at on 3/07/18 the resident was and she was the only staff grare to Resident #1 and the the bed. NA #1 stated she used at to get Resident #1 back into esistance. The administrator ted the sheriff's office and the with all the paper work and evestigation to the sheriff's office.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI		<del></del>		С	
		345534	B. WING				03/15/2018	3
NAME OF PROVIDI	ER OR SUPPLIER		•	STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
SANFORD HEA	LTH & REHABILIT	TATION CO			FARRELL ROAD			
				SAN	FORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	DATE	ETION
nurs havi nurs an ii coul 99% resid her pain the i havi nurs an \( \) to th hosp the i hem had furth antic blee prot the i befo aske him state  NA a PM. expe AM left s	ang increased parties thought it was increase in her N d not recall the earth of the time where the same seems of the time where the same seems of the time where the same seems of the time was a surgery and that she is a same seems of the time was a surgery yet at the same seems of the time was a surgery yet at the same seems of the time was a surgery yet at the same was a surgery was a	ce and said Resident #1 was in in her left leg and the neuropathic pain and wanted eurontin pain medication (he exact date). He stated that in he saw the resident, the ing in bed with the covers over sally never had complaints of Saturday morning (3/10/18), said the Resident was ft thigh and he thought the patient at that time. They got wed a display spiral fracture ent was admitted to the dent #1 got to the hospital, bothermic and her is. The Resident was close to and the Resident still has not be hospital. The Physician esident #1 was on apy and was probably in the thought the resident way of osteoporosis and stated that a fracture or break think of. He stated that he mat happened and she told of bed the other night and	F	689				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING			l	C <b>15/2018</b>	
NAME OF PROVIDER OR SUPPLIER  SANFORD HEALTH & REHABILITATION CO				270	REET ADDRESS, CITY, STATE, ZIP CODE 02 FARRELL ROAD ANFORD, NC 27330	1 03/	13/2010	
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Jeopardy on 3/14/18 1:41 PM, the facility peredible allegation of removal.  1. Resident #1 report 3/7/18 at approximate contacted physician vincreased Neurontin was notified on 3/7/18 order. The Resident rorders on 3/7/18. The 3/8/18 that Neurontin leg pain. Resident report Nurse #2 on 3/10/18. Assessment by Nurse pain upon palpation. by Nurse #2 with order was obtained on 3/10 indicated a left femur notified of results by I approximately 5:00ph resident to the hospitate RP was notified by Nurse #2 was notified by Nurse #4 resident's roommate CNA (nurse aide) rolled	s notified of Immediate at 2:22 PM. On 03/15/18 at provided the following Immediate Jeopardy  ed leg pain to Nurse #1 on ely 3:35 pm. Nurse #1 with new orders for on 3/7/18 at 6pm. The RP of c/o of pain and new reported relief with new e Resident reported on continued to be effective for ported increased leg pain to at approximately 3:00 pm. of #2 indicated increased Imperior increased Impe	F	689	DEFICIENCE			
	cognitively impaired, always understood ot assessment of 1/3/18	was usually understood, and hers per the MDS						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 03/1	5/2018	
NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO				STREET ADDRESS, CITY, STATE 2702 FARRELL ROAD SANFORD, NC 27330	, ZIP CODE	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIA' ICIENCY)		(X5) COMPLETION DATE	
F 689	the MDS assessmen roommate was intervous Director of Nursing at confided in any staff to onto the floor on 3/7/  The event occurred a follow facility procedures for and did not follow facility procedures for accidents/incidents. On the required two turning, repositioning #1 reported during the hurry to complete her for help as she felt shalone.  CNA #1 informed the approximately 11:30a on the morning of 3/7 rolled Resident #1 out CNA reported that she indicated resident recount in the shalon in a hurry assistance. CNA #1 resident recount in the shalon in a hurry assistance. CNA #1 resident recount in the shalon in the morning of 3/7 rolled Resident #1 out CNA reported that she indicated resident recount in the shalon in the shal	ays understood others per tof 12/28/17. The iewed on 3/11/18 by the end reported she had not that Resident #1 was rolled 18.  Is a staff member did not ures for following the care repositioning, did not follow ruse of a mechanical lift, illity procedures for reporting CNA #1 reported during an that she was aware of her ret accidents and injuries, and did not ask for assistance was available. Lide indicated that the person assistance with and incontinent care. CNA is interview that she was in a relast rounds and did not ask the could care for the resident.  DON on 3/11/18 at an that while providing care was aware that care path quires 2-person assistance,	F	689	CIENCT)			
	mechanical lift to tranded. CNA#1 stated to reporting requirement incident to anyone. C	sfer resident from floor to hat she was aware of ts, but failed to report the NA#1 was removed from the The Police were contacted						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345534	B. WING_			C 03/15/2018	
NAME OF PROVIDER OR SUPPLIER  SANFORD HEALTH & REHABILITATION CO				STREET ADDRESS, CITY, STATE, ZIP CO 2702 FARRELL ROAD SANFORD, NC 27330		03/19/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTI  CROSS-REFERENCED TO TI  DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	by the Director of Nur A 24-hour report for a Director of Nursing of The resident left the at approximately 5pm 2. A 100% skin asses completed by the Dirnurses on 3/11/18 incorporates on 3/11/18 until incorporates of the progress notes. No I beyond 3/11/18 until incorporates of the incorporate of the	rsing on 3/11/18 at 7:29pm. Abuse was submitted by the in 3/11/18 at 8:35pm. Facility with EMS on 3/10/18 in in transfer to the hospital.  Issment of all residents was ector of Nursing, and staff cluding assessment of ROM, in disgns/symptoms of pain.  Ints, the Director of Nursing and oriented residents if they eccidents, or falls. No fied  Interest of all licensed essment upon notification of and PROM and the dings in the resident's idensed staff will work they have received the ed licensed nursing staff will and certified nursing use of care guide, 2-person and use of mechanical lift. Although staffing was not an de aware that they can illicit staff member. No staff will until they have received the ed nursing staff will receive.	Fé	589			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER: A. BUIL		PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 03/15/2018	
	ROVIDER OR SUPPLIER  HEALTH & REHABILIT	ATION CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		03/13/2010	
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	abuse/neglect immer This in-service included accidents/injuries and neglect. This in-service included accidents/injuries and neglect. This in-service included accidents for the in-service accidents for the in-service will receive the in-service will receive the in-service will receive the in-service will observe 3 incided mechanical lifts Monweeks, then twice weaks, then twice weaks, then monthed resident is being lift according to the control of the incomposition of	of incidents/accidents and diately to the Charge Nurse. Hed that is safe to report do included the definition of the included instruction on the after a fall due to danger of the until assessed by a nurse. Wond 3/11/18 until they have the case. Newly hired nursing staff revice during orientation.  It tool, the unit managers x2 that of staff operating day through Friday x 2 the early x 2 weeks, then weekly the thing x 1 month to ensure that transferred via mechanical are guide and the resident's then designed the every other than the every other than the care guide and	F 6	89			
	plan. The Weekend turning/repositioning then every other week month to determine it	dent care guide and care Supervisor will observe on weekends x 2 weekends, ekend x 2, the monthly x 1 f the resident is being turned led according to the resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345534	B. WING _			C 03/15/2018	
	ROVIDER OR SUPPLIER  DHEALTH & REHABILI	TATION CO	,	STREET ADDRESS, CITY, STATE 2702 FARRELL ROAD SANFORD, NC 27330		0/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 689	the Unit Managers daily to identify any assure a full assess. The Weekend Supernotes each weekend complaints of pain thad been documen completed by the classidents, including nonverbal. Utilizing Managers x 2 will reidentify any nonvertof pain to assure a documented. The V review progress not identify any nonvertof pain to assure a documented. Audits Friday x 2 weeks, V weekly x 2 weeks, V weekly x 2 weeks, the monthly x 1 month.  The Director of Nurtols weekly x 8, the concerns  4. The Director of Nurtols weekly x 8, the concerns  4. The Director of Nurtols weekly x 8, the concerns  The Administrator weekly and recompodification of the part of the Administrator weekly as the concerns.	Note Review QI Audit Tool, x 2 will review progress notes resident complaints of pain to sment had been documented. ervisor will review progress d daily to identify any resident to assure a full assessment ted. Pain assessments are marge nurse each shift for all those residents who are a Pain Audit tool, the Unit eview progress notes daily to bal residents with complaints full assessment has been weekend Supervisor will tes each weekend daily to bal residents with complaints full assessment has been will assessment has been weekend Supervisor will tes each weekend daily to bal residents with complaints full assessment has been will occur Monday through weekends x 2, then twice then weekly x 4 weeks, then weekly x 4 weeks, then weekly x 1 for trends and the large will report the results of the Quality Assurance x 3 months for trends, mmendations for any	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
345534		B. WING_			C 03/15/2018		
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	CODE	03/15/2016	
SANEODD	HEALTH & REHABILITA	ATION CO		2702 FARRELL ROAD			
JANFORD	HEALIN & RENABILITA	ATION CO		SANFORD, NC 27330			
(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 X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From page The credible allegation 3:30 PM as evidence regarding in-servicing documentation and non-licensed staff we servicing about when when providing reside mechanical lift, and re incidents. Review of or revealed that staff pre who did not receive in	e 30  In was verified on 3/15/18 at by nurse's interviews on pain assessment, otification. Licensed and re interviewed on into use 2 person assistance ent care, proper use of the eporting of accidents and on- going in service records esent would receive training in servicing prior to working tion was made on 3/15/18 at					