DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u> 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			COM	E SURVEY PLETED
		345534	B. WING				C / 09/2018
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
SANFORD	HEALTH & REHABILITA				2702 FARRELL ROAD		
OAN ONE					SANFORD, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 550 SS=D	Resident Rights/Exer CFR(s): 483.10(a)(1)(§483.10(a) Resident I The resident has a rig self-determination, ar access to persons an outside the facility, ind this section. §483.10(a)(1) A faciliti with respect and dign resident in a manner promotes maintenanch her quality of life, reco individuality. The facil promote the rights of §483.10(a)(2) The faci access to quality care severity of condition, must establish and m practices regarding tr provision of services of residents regardless of §483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise	cise of Rights (2)(b)(1)(2) Rights. ght to a dignified existence, ad communication with and d services inside and cluding those specified in by must treat each resident ity and care for each and in an environment that we or enhancement of his or ognizing each resident's ity must protect and the resident. clility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her f the facility and as a citizen		550	DEFICIENCY)	RATE	9/5/18
	free of interference, c reprisal from the facili rights and to be supp	sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.

08/24/2018

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDIN	G		С
		345534	B. WING		0	8/09/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
	HEALTH & REHABILIT			2702 FARRELL ROAD		
SANFURL				SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 550	Continued From page	e 1	F 5	50		
		rights as required under this	10			
	subpart.					
		T is not met as evidenced				
	by:					
		on and staff interview, the		Preparation and or execut	ion of this plan	
		1 of 3 residents, who were		does not constitute admiss		
		lining room table their lunch		agreement by the Provider		
		me to maintain dignity with		facts alleged or conclusion		
	dining. (Resident #83	3). The findings included:		statement of deficiencies.		
	Posidont #83 was ad	Imitted on 7/9/18 with a		prepared and executed so is required by the provisior	•	
	diagnosis of Atrial Fit			Federal law.		
	Resident #83's admis	ssion Minimum Data Set		Resident #83 was not serv	ed her meal at	
	dated 7/17/18 indicat	ted severe cognitive		the same time as the other	resident's	
		xhibited behaviors. She was		seated at the same dining	-	
	coded for supervisior	n with eating.		lunch on August 6, 2018. U		
				identification by the survey	•	
	-	plan dated 7/17/18 indicated		Assistant #5 retrieved Res meal from the meal-tray ca		
	needed.	ith activities of daily living as		Assistant #5 stated that sh	•	
	neeueu.			that residents should be se		
	During an observatio	n on 8/6/18 at 12:55 PM, the		same time and she must h		
	meal-tray cart for hal			it. Resident #83 was serve	-	
	-	oserved sitting at a table in		upon notification that the re	esident had not	
	the dining room on h	all 300 with two other		been served.		
	residents. The two o	ther residents seated at the				
		83 received their meal trays		The resident did not receiv		
		sident #83 continued to sit at		the same time as the other		
		I, Resident #83 still had not		seated at the same dining		
		rsing Assistant (NA) #5 al trays from the tables of the		was no designated person observe the dining process		
		hished their lunch. NA #5 was				
		esident #83 not receiving her		Licensed Nurses will be as	signed to	
		#5 stated she did not realize		oversee each dining room	-	
		d not been served her meal		times to ensure that reside	-	
		meal tray was still on the		maintained and meals are		
		5 retrieved Resident #83's		residents seated at the sar		
	meal tray and set it u	p for Resident #83. NA #5		same time.		

Facility ID: 20050005

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345534	B. WING		C 08/09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SANFOR	HEALTH & REHABILIT			2702 FARRELL ROAD	
				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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	JLD BE COMPLETION
F 550	stated residents sittin be served at the sam just missed it, but it w In an interview on 8/9 Administrator stated i	g at the same table should e time and she must have vas not done intentionally. 9/18 at 4:10 PM, the t was her expectation that ther should be served their	F 55	 A 100% audit of each dining room reach meal served was completed of 7 days, specifically August 21, 201 through August 27, 2018, by licens nurses to ensure that each resident dignity was maintained during meat that all residents seated at the same time August 23, 2018 one resident's or orincorrect (resident ordered from alt menu) and the nurse went to the kit to get the corrected tray. This reside was served upon retrieval of tray fr kitchen. On August 23, 2018, one resident's tray was sent to the incordining room and staff retrieved the from the incorrect dining room and staff retrieved the from the incorrect dining room and staff retrieved the from the incorrect dining room and resident's tray will be sent to 3 dining room from now on. On Augu 2018, two resident's trays were del to the 100 hall dining room with incordiet consistencies. The nurse retriet the correct trays from kitchen staff residents were served upon retrievent trays. No other issues were noted of the dates of August 21, 2018 throut August 26, 2018. The Assistant Director of Nursing in an in-service to all nursing departm staff on August 20, 2018 regarding resident's rights and dignity during times. This in-service included that charge served to residents dining same table at the same time. This in-service also included that charge served to residents dining same table at the same time. This in-service also included that charge serves and the charge serves and the same time. This in-service also included that charge serves and the same time. This in-service also included that charge serves and the same time. This in-service also included that charge serves and the same time. This in-service also included that charge serves and the same time. This in-service also included that charge serves and the same time. This in-service also included that charge serves and the same time. This in-service also included that charge serves and the same time. This in-service also included that charge service the serves and the serves the charg	daily for 8 sed it's is and he table he. On der was sernate itchen lent om rrect tray the eval. d and 00 hall ist 23, livered correct eved and al of during gh hitiated hent meal meals at the

Event ID: S6KG11

Facility ID: 20050005

If continuation sheet Page 3 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 09/04/2 FORM APPROV OMB NO. 0938-03
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345534	В. \	WING		C 08/09/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	00/03/2010
	HEALTH & REHABILIT			2	2702 FARRELL ROAD	
SANFOR				S	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETI
F 550	Continued From page			F 550	nurses will be assigned to oversee ea dining room during all meals. All newly hired nursing department staff will rec the appropriate education during orientation. Staff will not be allowed to work until they have received the in-service. To ensure quality assurance, utilizing dining room observation quality assura audit tool, licensed nursing staff will complete dining room observations du meal times to ensure dignity is mainta during meals and that meals are provi to all residents at the same time. Thes audits will be completed daily for two weeks, twice weekly for two additional weeks, and weekly for two months. Th Director of Nursing will review the qua assurance audit tools weekly x 8 week then monthly x 1 month for trends and concerns. The Director of Nursing will present the results of these audits to the Quality Assurance Performance Improvement Committee for a minimum of three consecutive meetings to identify trend concerns, and recommendations for a modification of the process. The Director of Nursing will be responsible for implementing the plan correction.	y eive a ance uring ined ded se l he ulity ks, t e t s, uny
F 600 SS=D	CFR(s): 483.12(a)(1)	-		F 000		01010
	3-03.121166000110	אויקטעשב, אבטובטו, מווע				
RM CMS-256	7(02-99) Previous Versions Obs	solete Even	t ID: S6KG11	Fa	acility ID: 20050005 If cont	inuation sheet Page 4 o

Facility ID: 20050005

If continuation sheet Page 4 of 81

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 09/04/201 RM APPROVE IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		TE SURVEY IPLETED
		345534	B. WING		0	C 8/09/2018
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
SANFORD	HEALTH & REHABILIT			2702 FARRELL ROAD		
	TEACHI & REHADICH			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 COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 600	Continued From page 4		F 60	00		
	neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to				
	§483.12(a) The facilit	y must-				
	physical abuse, corpo involuntary seclusion This REQUIREMENT by: Based on record rev resident interview, the cognitively impaired r unwanted advances f resident (Resident # 0 provide incontinent ca	; is not met as evidenced iew, observation, staff and e facility failed to protect a resident (Resident #62) from from a cognitively intact 60) and also neglected to are to a resident who needed		On August 6, 2018, Nursing A reported to Nurse #5 that she of Resident #60 kiss Resident #6 lips. Nursing Assistant #3 left th residents alone to go and repo incident to the nurse. Upon hea	observed 2 on the he rt the aring of the	
	2 of 2 sampled reside neglect.	toileting (Resident #65) for ents reviewed for abuse and		incident, Nursing Assistant #6 Resident #62 from the location incident. Nurse #5 completed a head-to-toe assessment of Re	of the a sident #62	
	Findings included:			with no abnormal findings. At the occurrence on August 6, 2018,	, Resident	
	facility on 4/14/14 and with multiple diagnosi quarterly Minimum Da	originally admitted to the d was readmitted on 8/9/17 es including dementia. The ata Set (MDS) assessment d that Resident #62 had		#60 was immediately provided one-on-one sitter. A complete thorough investigation was cor reported to DHSR.	and	
	severe cognitive impa			Nursing Assistant #3 failed to e safety of Resident #62 as she		
	9/5/16 and was readr multiple diagnoses in	mitted to the facility on nitted on 3/29/17 with cluding diabetes mellitus. ssessment dated 7/2/18		separate the residents and left residents alone to go and repo incident to the nurse.	the	

Facility ID: 20050005

If continuation sheet Page 5 of 81

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DAT	O. 0938-03
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CON	IPLETED
						С
		345534	B. WING		0	8/09/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI	P CODE	
				2702 FARRELL ROAD		
SANFURL	D HEALTH & REHABILIT	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 (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 5	F 60	00		
		nt #60 had intact cognition		On July 11, 2018, Nursir	ng Assistant #6	
		w for mental status (BIMS)		failed to provide incontin	-	
		essment further indicated		Resident #65 from appro		
		eded limited assistance with		until 8:45PM. Upon iden		
	locomotion on and of	f unit using a walker or a		Resident #65 was provid		
	wheelchair for mobilit	ty.		care by Nursing Assistar	nt #1. An	
				investigation was initiate		
	An incident investigat	tion report was provided by		and Nursing Assistant #	6 terminated on	
	the Administrator on	8/9/18. The report revealed		July 13, 2018.		
	that the Administrator	had received a phone call				
	from the Director of N	lursing (DON) on 8/6/18 at		The facility investigation	included	
		The call was to inform her		interviewing all residents		
	that a Nurse Aide (NA) had observed Resident 13-15 to determine if there were a	•				
	-	ssing Resident #62. The Administrator had concerns for abuse or neglect; however,	-			
	-	interviewed the NAs and		the facility failed to conta		
		NA # 3 reported that she had		representatives of all res		
		#60 leaned forward and		BIMS score of less than		
		near her lips. NA #3 left the		there were any concerns	s for abuse or	
		the nurse. NA # 6 reported		neglect.		
	that when she heard				2 of 10 15 word	
		the media room and as she		All residents with a BIMS		
		e heard Resident #60 asking		interviewed on August 1 Director of Nursing, Adm		
	Resident #62 if he co	6 immediately instructed		Coordinator, Administrat		
		e the room. Nurse #5		Worker to determine if th		
		s at the 100 hall nurse's		concerns for neglect with	,	
		informed her of the incident.		neglect reported. Intervie		
		after ensuring the safety of		responsible representati		
		tified the DON via phone.		with a BIMS of less than		
		a full skin assessment on		on August 11, 2018 by th		
	Resident #62 with no			Nursing, Admissions Co		
		lso indicated that she notified		Administrator, and Socia		
	-	of Resident #62 and the		determine if there were a	any concerns for	
	nurse assigned to Re	sident #60. When she		neglect. Interviews were	completed on	
	interviewed the reside	ent, Resident #60 denied the		August 14, 2018 with no	incidents of	
	allegations of kissing	and asking to touch		neglect reported.		
		. The investigation report				
	further indicated that			The Administrator provid		
	regidente wore intervi	iewed by the Director of		to all Administrative Staf	f on August 20	

Facility ID: 20050005

If continuation sheet Page 6 of 81

	OF DEFICIENCIES	MEDICAID SERVICES				MB NO. 0938-0
	CORRECTION	IDENTIFICATION NUMBER:	1 ° <i>î</i>	E CONSTRU		COMPLETED
			A. BOILDING			С
		345534	B. WING			08/09/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP CODE	00/00/2010
				2702 FARRE	ELL ROAD	
SANFORD	HEALTH & REHABILIT	ATION CO		SANFORD,	, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLET DATE
F 600	Continued From pag	e 6	F 60	2		
		S) on 8/9/18 with no reports	1 00		egarding complete and accurate	
		hing or communication.			gating of abuse and neglect. This	
	Resident #62 was in	-			rice included a review of the facility	/
	Administrator and the			prevention program and policy for		
	allegations.				investigating and reporting. All	
				-	hired administrative staff will	
		t from NA # 3 revealed that			e the appropriate education during	
		s walking up the 100 hall, she ting in a Geri-chair facing the			tion. Staff will not be allowed to ntil they have received the	
1		ent #60 was sitting on the left		in-serv		
		in the media room. She saw				
		toward Resident #62 and		The As	sistant Director of Nursing initiate	d
	she thought they we			ervice to all staff on August 20,		
	watched them, she s	aw Resident #60 kissed			egarding abuse and neglect. This	
		lips. She then went and			ice included appropriate actions to	
	reported it to the Nur	se #5.			hen abuse is suspected, including	
	The written statemer	nt from NA #6 revealed that			ng the immediate safety of the nt involved. This in-service include	d
		nately 9 PM, while standing			les of abuse and neglect, including	
	at the nurse's station				nt to resident abuse, and a review	9
		and stated that Resident			ity policies and procedures for	
		sing Resident #62. She			and neglect. All newly hired	
		room and noticed Resident		nursing	g department staff will receive the	
		sident #62. Resident #62			priate education during orientation.	
		acing the television and she			ill not be allowed to work until the	y
		#60's back as she was		have re	eceived the in-service.	
		bom. She did not see him however she heard him			ssistant Director of Nursing initiate	d
		"can I touch your titties?"			ervice to all nursing assistants on	
	•	Resident #60 to leave the			t 20, 2018 regarding incontinent	
	room which he did.				s, following resident specific care	
				-	, and timely response to call lights	s.
		nt from Nurse # 5 revealed			-service included providing timely	
		d on 8/6/18 around 9 PM			residents returning to the facility	
		as in the media room on the			ppointments or other leaves of	
	-	her resident and he was			ce. All newly hired nursing	
		er. She then went to talk to denied the allegations.			ants will receive the appropriate ion during orientation. Staff will no	st
	1 1 to show π 00 and π	actica inclancyations.			wed to work until they have	~

Facility ID: 20050005

If continuation sheet Page 7 of 81

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		E SURVEY IPLETED
		345534	B. WING			08	C 3/09/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				2	702 FARRELL ROAD		
SANFURL	HEALTH & REHABILIT	ATION CO		s	ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	a 7		600			
1 000	The psychiatry consu			000	received the in-service.		
	the incident with Resi	ident #62 was discussed d when he was interviewed.			To ensure quality assurance, the Administrator will review all reports of		
		regretted that it happened but			abuse and neglect in entirety to ensure	<u>,</u>	
		e not to touch anyone here in			that appropriate action was taken to		
	-	e would be lying if he said he			ensure the safety of the resident. Any		
		. The plan was to observe			employee witnessing abuse and not	h -	
		e for inappropriate behaviors alone with any females.			ensuring the safety of the resident will disciplined according to policy.	be	
	On 8/9/18 at 1:10 PM				To ensure quality assurance, utilizing a	ı	
		e was talking incoherently			Resident Interview for Neglect quality	_	
	when questioned.				assurance audit tool, the Social Worke will interview 5 residents with a BIMS of		
	On 8/9/18 at 1:30 PM	1. Resident #60 was			13-15 and 5 Responsible Representati		
		sked of the incident with			of residents with a BIMS less than 13 to		
		nitted kissing her on her lips			ensure no neglect of care has occurred		
		er asking her if he could			These audits will be completed weekly	x 4	
	touch her breast.				weeks then monthly x 2 months. The Administrator will review the audit tools		
	On 8/9/18 at 1:15 PM	1, NA # 6 was interviewed.			weekly x 4 weeks, then monthly x 2)	
	She stated that she o	overheard NA #3 informing d observed Resident #60			months for trends and concerns.		
		. She immediately went to			The Director of Social Services will		
		while entering the room she			present the results of these audits to the	e	
		asking Resident #62 if he			Quality Assurance Performance		
		 He was leaning forward close to Resident #62's 			Improvement Committee for a minimum of three consecutive meetings to identi		
		ly told him that he needed to			trends, concerns, and recommendation		
	leave the room and s				for any modification of the process.		
		l, NA #3 was interviewed.			The Administrator will be responsible for	or	
		vas walking down the hall			implementing the plan of correction.		
	-	room. She saw Resident #60 actually kissing Resident #62					
		eft the room and went to the					
		orm Nurse #5. When asked					
	why she left the room	n, she replied that she was					

If continuation sheet Page 8 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345534	B. WING			30	C 6/ 09/2018
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
SANFORE	HEALTH & REHABILITA	ATION CO			2702 FARRELL ROAD SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	On 8/9/18 at 1:10 PM She stated that NA #3 was walking down the saw Resident #60 lea Resident #62 in the m informed by NA # 6 th asking Resident #62 if When she interviewed the allegation. She a Resident #60 out of th completed a full body #62 and nothing usua indicated that Resided Resident #60 was ale On 8/9/18 at 12:02 Pf interviewed. She state happened on 8/6/18 at was informed of the in facility and interviewed indicated that Resided oriented but Resident The allegation was Re #62 and asked her if if She indicated that she abuse allegations. The abuse and all alert an	ink of separating them. , Nurse #5 was interviewed. B informed her that while she a 100 hall around 9 PM she uning forward and kissing hedia room. She was also hat she heard Resident #60 if he could touch her titties. d Resident #60, he denied lso observed NA #6 taking he media room. She assessment on Resident al noted. Nurse #5 further ht #62 was confused while ert and oriented. M, the Administrator was	F	600			
	5/2/18 with cumulative	admitted to the facility on e diagnoses of Peripheral d-Stage Renal Disease and					

If continuation sheet Page 9 of 81

		D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345534	B. WING				C / 09/2018
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SANFORD	HEALTH & REHABILITA	ATION CO			2702 FARRELL ROAD SANFORD, 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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	9	F	600			
	dated 6/22/18 indicate his activities of daily li incontinent care due to bladder and bowel. Review of Resident # Minimum Data Set dat moderate cognitive im	65's re-admission 5-day ited 7/9/18 indicated apairment with no behaviors					
	with hygiene. He was	and always incontinent of					
	indicated on 7/11/18 a was not offered incon from dialysis at 4:45 F (Resident #258) requ Resident #65 at 8:55 Investigation Report of Resident #258 was in PM. He described how left sitting up in his wit clothes since returnin approximately 4:45 P was incontinent of boy in his soiled brief until call bell for staff to ass approximately 8:55 P substantiated, and the 7/13/18.	dated 7/13/18 indicated terviewed on 7/11/18 at 9:10 w Resident #65 had been neelchair wearing his street g from dialysis at M. He stated Resident #65 wel and had been left sitting Resident #258 pushed his sist Resident #65 at M. The FRI was e aide was terminated on					
	8/8/18 at 9:00 AM. He	mpted with Resident #65 on e did not recall the incident he was happy at the facility ns.					

If continuation sheet Page 10 of 81

	DEFICIENCIES	X MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	` '		· · ·	E SURVEY IPLETED
			A. DOILDING			С
		345534	B. WING			B/09/2018
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		5/05/2010
				2702 FARRELL ROAD		
SANFORD	HEALTH & REHABILI	TATION CO		SANFORD, NC 27330		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO
F 600	Continued From page	de 10	F 60	0		
		admitted 5/5/18. He was	1 00			
		ospital on 7/30/18. His				
	•	Data Set dated 5/16/18				
	indicated he was cognitively intact and exhibited					
	no behaviors.					
	•	Resident #258 and his				
	Responsibly Party w	vere unsuccessful.				
	In a telephone interv	view on 8/8/18 at 1:50 PM,				
	•	IA) #6 stated she was the				
	•	incident on 7/11/18 and				
	confirmed she was	suspended then terminated				
	on 7/13/18. She stat	ted she arrived at work daily				
		e was in school. She stated				
		Inment had been changed				
	-	nment on hall 300 to the 100 and she was unfamiliar				
		. NA #6 stated Resident #258				
		at approximately 8:45 PM so				
	•	at he needed. She stated				
	Resident #258 was	angry when she went in and				
	stated Resident #65	needed to be undressed,				
		d to bed. She stated Resident				
		l informed her he was				
	the time he returned	assisting Resident #65 from				
		PM to 8:45 PM. NA #6 stated				
	•••	as using his call bell for				
	-	hat it was fine if he reported				
		left the room without				
		ance to Resident #65				
		258 was so angry. She stated				
		wed her out of the room and				
		nursing station. NA #6 stated				
		into the room and assisted ndressing and incontinence				
		-				
	care when the Direc	tor of Nursing came in and				

Facility ID: 20050005

If continuation sheet Page 11 of 81

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
			5.000			С
		345534	B. WING		08	8/09/2018
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
SANFOR	D HEALTH & REHABILIT	ATION CO	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 PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 600	see her immediately NA #6 stated when s care to Resident #65 of diarrhea. She state incontinence care wa while at dialysis and received incontinence 3:45 PM. During an observation Resident #65's brief Observation of his pe #2 stated Resident # episodes of diarrhea often. NA #2 stated dialysis every Monda and left the facility be NA #2 stated incontin Resident #65 prior to was not preformed a she left at 3:00 PM. In an interview on 8/8 Director of Nursing (I incident stated she w she was notified by ti that there was a prot she heard NA #6 cor and when exiting her #258 also coming up appeared upset. The immediately went to approximately 8:55 F his wheelchair in his obviously very soiled Resident #65 normal	e 11 after writing her statement. he provided incontinence b, he had apparent episodes ed she did not know if as provided to Resident #65 uncertain when he last e care prior to her arrival at on on 8/9/18 at 10:10 AM, was noted clean and dry. eri-area was noted intact. NA 65 often experienced and needed to be changed Resident #65 attended ay, Wednesday and Friday efore lunch on those days. hence care was provided to be leaving for dialysis and it gain until he returned after 9/18 at 10:20 AM, the DON) at the time of the vas in the DON office when he Medication Aide (MA) #1 blem with NA #6. She stated ming up the hallway yelling office, she saw Resident to the hallway and he too e previous DON stated she check on Resident #65 at PM who was still sitting up in street cloths and was with stool. She stated lly returned from dialysis he would not have received	F 600	DEFICIENCY)		

If continuation sheet Page 12 of 81

TATEMENT C	S FOR MEDICARE & F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY PLETED
						С
		345534	B. WING			8/09/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
SANFORD	HEALTH & REHABILITA	ATION CO		2702 FARRELL ROAD 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 600 F 607 SS=D	Resident #258 to the statement. She direct statement and clock of pending the outcome. In an interview on 8/9 stated she was assign 7/11/18. She stated s Resident #258 yelling coming up the hallwa immediately notified t working in her office t and she needed assist. In an interview on 8/9 Administrator stated F received any incontin left for dialysis that da PM. She stated it was Resident #65 would h gotten out of his whee care provided upon re Develop/Implement A CFR(s): 483.12(b)(1) Prohibit neglect, and exploitat misappropriation of received and exploitat misappropriation of received and she here the facility in	he and the (MA) #1 took conference room to get his ted NA #6 to write her but due to suspension of the investigation. 0/18 at 1:20 PM, MA #1 ned Resident #65 on he heard NA #6 and g and observed them both y. She stated she the previous DON who was that something happened, stance. 0/18 at 4:10 PM, the Resident #65 would have not ence care from the time he ay until approximately 8:55 is her expectation that have been immediately elchair and incontinence eturn from dialysis. Abuse/Neglect Policies -(3) cy must develop and licies and procedures that: it and prevent abuse, tion of residents and esident property, sh policies and procedures	F 600			9/5/18
	§483.12(b)(3) Include paragraph §483.95,	e training as required at				

Facility ID: 20050005

If continuation sheet Page 13 of 81

			()(0) 14111 710			NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · · ·	ATE SURVEY
			A. DOILDING			С
		345534	B. WING			08/09/2018
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		00/00/2010
				2702 FARRELL ROAD		
SANFURL) HEALTH & REHABILIT/	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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	Continued From page	- 13	F 60	7		
		is not met as evidenced	1.00			
	by:					
		iew, and staff interview, the		On August 6, 2018, a resident	to resident	
	facility failed to follow	their abuse policy and		abuse investigation was initiate	ed. The	
		orting allegation of abuse		Administrator did not report this	-	
	immediately to the sta			to DHSR in a timely manner. T		
	-	viewed for abuse and		allegation report was submitted		
	neglect (Resident #62	2).		9, 2018, three days after the in occurred.	cident	
	Findings included:					
				The Administrator failed to follo	w the	
	The facility's abuse p	olicy and procedure with the		abuse policy and procedure by	not	
		2017 was reviewed. Under		reporting an allegation of abus		
		ndicated that "all alleged		immediately to the state agenc	у.	
	-	buse, neglect, exploitation or				
		ng injuries of an unknown priation of property will be		All reportable allegations/incide occurring over the previous thr		
		y Administrator or his/her		were reviewed by the Administ		
		ving persons or agencies:		August 17, 2018 to ensure time		
	the state licensing/ce			reporting with no issues identif		
	_			reportable allegations/incidents	occurring	
	Resident #62 was ori	ginally admitted to the facility				
		readmitted on 8/9/17 with		The Regional Director of Opera		
		cluding dementia. The		provided an in-service to the A		
		ata Set (MDS) assessment d that Resident #62 had		on August 20, 2018 to include reporting of abuse allegations.	•	
	severe cognitive impa			in-service included a review of		
		annont.		abuse prevention program and		
	-	tion report was provided by 8/9/18. The report revealed		abuse investigating and reporti		
		had received a phone call		The Administrator provided an	in-service	
		lursing (DON) on 8/6/18 at		to all Administrative Staff on Au	-	
		The call was to inform her		2018 regarding complete and a		
		A) had observed Resident		investigating of abuse and neg		
	-	#62. The Administrator had		in-service included a review of	-	
		interviewed the NAs and NA # 3 reported that she had		abuse prevention program and abuse investigating and reporti		
		60 leaned forward and		newly hired administrative staff		
		near her lips. NA #3 left the		receive the appropriate educat		

Facility ID: 20050005

If continuation sheet Page 14 of 81

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		LETED
		245524				2
		345534	B. WING			09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
SANFOR	DHEALTH & REHABILIT	ATION CO		2702 FARRELL ROAD 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 O (EACH CORRECTIVE AO CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 607	Continued From page	<u>9</u> 14	F 60	17		
	media room to inform that when she heard immediately went to t entered the room, she Resident #62 if he co (female breast). NA # Resident #60 to leave reported that she was station when NA # 3 i Nurse #5 stated that a Resident #62 she not She also completed a Resident #62 with no findings. Nurse #5 al the responsible party nurse assigned to Re interviewed the reside allegations of kissing Resident #62's titties. On 8/9/18 at 3:20 PM She stated that she w looking at the media of leaning forward and a on her mouth. She le nurse's station to info	the nurse. NA # 6 reported the incident, she he media room and as she e heard Resident #60 asking uld touch her "titties" 6 immediately instructed e the room. Nurse #5 s at the 100 hall nurse's nformed her of the incident. after ensuring the safety of ified the DON via phone. a full skin assessment on abnormal or unusual so indicated that she notified of Resident #62 and the esident #60. When she ent, Resident #60 denied the and asking to touch d, NA #3 was interviewed. vas walking down the hall room. She saw Resident #62 actually kissing Resident #62 eft the room and went to the		 orientation. Staff will not the work until they have received in-service. To ensure quality assurant of Nursing will submit all rallegations of abuse and appropriate agencies and Administrator will review a entirety to ensure that appreporting has occurred performance linear submitted. The Regio Operations will be notified that are not submitted time disciplinary action can occurred a minimum of three conset to identify trends, concern 	ived the nce, the Director reportable neglect to the all reports in propriate er policy. nce, utilizing an ting QI tool the t an audit of all r the next three recifically outline dates that reports nal Director of d of any reports nely so that cur per policy. esent the results ality Assurance nt Committee for ecutive meetings	
	Nurse #5 that she hat kissing Resident #62. the media room, and	verheard NA #3 informing d observed Resident #60 . She immediately went to while entering the room she asking Resident #62 if he		recommendations for any the process. The Administrator will be implementing the plan of	responsible for	
	She stated that NA #3 was walking down the	l, Nurse #5 was interviewed. 3 informed her that while she e 100 hall around 9 PM she aning forward and kissing				

Facility ID: 20050005

If continuation sheet Page 15 of 81

	S FOR MEDICARE 8				OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING	i	
		345534	B. WING		C 08/09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/09/2018
				2702 FARRELL ROAD	
SANFORE	D HEALTH & REHABILI	TATION CO		SANFORD, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 607	Continued From page	ne 15	F 60	7	
1 001	Resident #62 in the media room. She was also		1 00		
		that she heard Resident #60			
	asking Resident #62 if he could touch her titties.				
	Nurse #5 indicated	that she had reported the			
	incident to the Direct	tor of Nursing.			
	0.0/0/40.40.00				
		PM, the Administrator was ated that the incident			
		ated that the incident at night. She was called and			
		incident. The allegation was			
		d Resident #62 and asked her			
	if he could touch he	r titties. She indicated that			
	she considered the	se as abuse allegations. The			
		I that she did not report the			
	-	e because the corporate had			
	reportable.	t to resident abuse was not			
F 641	Accuracy of Assess	ments	F 64	1	9/5/18
SS=D		mento	1 04		3/3/10
	§483.20(g) Accurac	-			
	resident's status.	ust accurately reflect the			
		IT is not met as evidenced			
	by:				
	Based on record re	view, observation, and staff		Resident #18 had an active order for	
		ty failed to code the Minimum		Norco once daily for chronic back pair	
	, ,	sessment accurately in the		Section (I) of the MDS on the 5/24/18	
		nosis and antipsychotic		assessment indicated no diagnosis	
	-	Resident #18), falls (Resident itus (Resident #2) for 3 of 27		related to pain medication.	
	residents reviewed.	$\pi = (\pi = 0) = (\pi = 1) = (\pi = 1) = (\pi = 1) = (\pi = 1)$		Resident #18's Seroquel was	
				discontinued on 4/3/18 and Risperdal	
	The findings include	ed:		initiated. Section (N) of the MDS on	
				5/24/18 inaccurately coded to indicate	e that
		as admitted to the facility on		a GDR had been attempted.	
	5/22/17 with diagno				
	osteoarthritis and cl	aronio noin		Resident #72 had a fall with head inju	m /

Event ID: S6KG11

Facility ID: 20050005

If continuation sheet Page 16 of 81

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION		NO. 0938-039 TE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G) ´co	MPLETED
						С
		345534	B. WING		(08/09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
SANFOR	D HEALTH & REHABILIT	ATION CO		2702 FARRELL ROAD		
SANION				SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 641	Continued From pag	e 16	F 64	11		
				on 4/19/18. Section (J) of	of the MDS	
	A physician' s order f	for Resident #18 dated 3/7/18		submitted on 7/5/18 was	scoded	
		cotic pain medication)		inaccurately for falls.		
	back pain.	ng) once daily for chronic		Resident #2 was admitte	d to the facility	
	раск раш.			with a chipped tooth. Se		
	A physician ' s note o	dated 5/16/18 indicated		MDS on 5/1/18 was inac		
		d for Resident #18 's chronic		having no dental issues.		
				The nurse documented	-	
	The annual Minimum			regarding a fall for Resid		
		24/18 indicated Resident 18		incorrect date, utilizing the	-	
		rerely impaired. She received n 7 of 7 days during the MDS		rather than 2018, therefore MDS Coordinator review		
		on I, the Active Diagnoses		log for this resident the f		
	-	diagnosis related to the		incident log. Based on th		
	opioid medication.			being incorrectly entered		
				Coordinator was unawa	re of the fall for	
		Resident #18 included the		Resident #72 and theref		
		with diagnoses of arthritis,		fall on the MDS. The ME		
		nd back pain at times. This		failed to code a diagnost		
	area was initiated on	5/24/18.		for a resident prescribed for Resident #18. The M		
	An interview was cor	nducted with the MDS Nurse		incorrectly coded a GDF		
		1. The MDS dated 5/24/18		when the resident had a		
	for Resident #18 that	t indicated she received		medication but not a GD	•	
	opioid medication on	7 of 7 days was reviewed		failed to assess Resider	nt #2's dentation	
		The Active Diagnoses		prior to completing an as	ssessment.	
		8 MDS that provided no			- th - 5/04/40	
	•	the opioid medication was		Section (I) of the MDS o assessment for Residen		
		DS Nurse. The physician ' s the plan of care related to		corrected to reflect a dia		
		were reviewed with the		Pain and resubmitted or	-	
	-	vealed the MDS was coded		MDS Coordinator.		
		ated the 5/24/18 MDS for				
	-	have included the diagnosis		Section (N) of the MDS	on the 5/24/18	
	of chronic pain.			assessment for Residen		
				corrected to reflect that a		
	An interview was cor	nducted with the		attempted and resubmit	ted on 8/14/18 by	

Facility ID: 20050005

If continuation sheet Page 17 of 81

		ND HUMAN SERVICES MEDICAID SERVICES				PRINTED: 09/04 FORM APPR OMB NO. 0938	OVE
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	/
		345534	B. WING			C 08/09/201	8
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET AD	DRESS, CITY, STATE, ZIP CODE	-	
				2702 FARR	RELL ROAD		
SANFORL	HEALTH & REHABILIT	ATION CO		SANFOR	D, 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 APPROPRIA DEFICIENCY)		ETION
F 641		- 47					
F 04 I	Continued From page		F 64				
	Administrator on 8/9/	18 at 4:10 PM. She ed the MDS to be coded		the M	DS Coordinator.		
	accurately.			Sectio	on (J) of the MDS on the 4/19/18		
					ssment for Resident #72 was		
	1b. Resident #18 was	s admitted to the facility on		correc	cted to reflect that the resident		
	5/22/17 with diagnos	es of vascular dementia with		sustai	ined a fall and resubmitted on		
	behavioral disturband	ce.		8/14/1	18 by the MDS Coordinator.		
	A review of a psychia	atry progress note dated		Sectio	on (L) of the MDS on the 5/1/18		
	4/3/18 indicated the	physician was changing		asses	ssment for Resident #2 was		
		psychotic medication from			cted to reflect a chipped tooth and	1	
		otic medication) to Risperdal			mitted on 8/22/18 by the MDS		
	(antipsychotic medica	ation).		Coord	dinator.		
		dated 4/3/18 indicated			nterdisciplinary Team, including th	e	
		oquel was discontinued and			ry Manager, Dietician, and MDS		
	Risperdal was initiate	ed.			dinator were in-serviced by the		
					prate MDS Consultant on 8/23/18		
	The annual Minimum			regard	ding accuracy of assessments.		
		24/18 indicated Resident 18		The A	esistent Director of Number initiat	a d	
	-	erely impaired. Section N, on, indicated Resident #18			Assistant Director of Nursing initiat service on 8/21/18 with all license		
		tipsychotic medications on 7			ng staff regarding accuracy of	u	
		sychotic Medication Review			mentation on incident reports. All		
		18 had received routine			hired licensed nursing staff will		
		tion and that a Gradual Dose		-	/e the appropriate education durin	a	
		s attempted on 4/3/18.			ation. Staff will not be allowed to	.9	
		·			until they have received the		
	An interview was cor	nducted with the MDS Nurse		in-ser	-		
	on 8/9/18 at 3:50 PM	. The MDS dated 5/24/18					
		indicated a GDR was					
	· ·	was reviewed with the MDS			idit was initiated by the Regional		
		ry progress note dated			e Consultant on 8/23/18 to ensure		
		cian 's order dated 4/3/18			ssment accuracy of all sections.		
		continuation of Resident #18			bers of the Interdisciplinary Team		
		initiation of Risperdal was			ted in the audit following		
		DS Nurse. The MDS Nurse			ucation on 8/23/18. All active ents' last assessment was audited	.	
		aware that a tapering of an tion performed for the			sessment accuracy between 8/23		
	anupsycholic medica				Sessment accuracy Detween 0/23	10	

Facility ID: 20050005

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) D	ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	l` í	G	· · · ·	MPLETED
						С
		345534	B. WING			08/09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	, ZIP CODE	
SANFOR	HEALTH & REHABILIT	ATION CO		2702 FARRELL ROAD SANFORD, NC 27330		
		ATEMENT OF DEFICIENCIES		,	AN OF CORRECTION	(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	YE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIOI DATE
F 641	Continued From page	e 18	F 64	11		
		the resident from one		and 8/24/18. Of 105 as	ssessments	
		tion to another was not to be		audited, 26 assessme		
	coded as a GDR on t	the MDS. She indicated she incorrectly for Resident #18.		and re-submitted on 8		
	She reported Reside	nt #18 ' s 5/24/18 MDS		In order to provide Qua	-	
		ded to indicate a GDR was		Interdisciplinary Team	-	
	not attempted.			MDS audit to ensure a		
	An interview was con	ducted with the		accuracy on one asset for 4 weeks and one p		
	Administrator on 8/9/			additional two months.		
	indicated she expected	ed the MDS to be coded				
	accurately.			The MDS Coordinator	will present the	
				results of these audits		
	0. Desident #70			Assurance Performant		
		most recently readmitted to		Committee for a minim consecutive meetings		
		the facility on 8/25/16 with diagnoses that included cerebrovascular disease, heart failure,		concerns, and recomn		
	and respiratory failure.			modification of the pro	•	
	-	4/19/18 indicated Resident		The Administrator will	be responsible for	
	#72 had a fall with he			the plan of correction.		
		atoma, was evaluated at the				
		id neck CT (computed ompleted with negative				
	findings, and he retur					
	The quarterly Minimu	ım Data Set (MDS)				
		5/18 indicated Resident #72				
		t. He was coded with no falls				
	significant change MI	DS assessment (4/6/18 DS).				
		ducted with the MDS Nurse				
		. The 7/5/18 MDS for				
		licated he had no falls since				
		sessment was reviewed with				
		e nursing note dated 4/19/18 ent #72 had a fall with head				
	injury was reviewed v					

If continuation sheet Page 19 of 81

		MEDICAID SERVICES	(X2) MULT		ONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '			· · ·	PLETED
							С
		345534	B. WING			08	8/09/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
SANFOR	DHEALTH & REHABILIT	ATION CO		2702	2 FARRELL ROAD		
0,111 0112				SAN	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 641	Continued From page	e 19	F 6	341			
		ded Resident #72 ' s 7/5/18		, , , ,			
	MDS inaccurately for	falls.					
	An interview was con	ducted with the					
	Administrator on 8/9/						
		ed the MDS to be coded					
	accurately.	dmitted on 4/24/18 with a					
	diagnosis of Traumat						
	(MDS) dated 5/1/18 in cognitive impairment assistance with all ac for supervision with e Status) of the MDS w broken or chipped tee	sion Minimum Data Set ndicated she had severe and required total tivities of daily living except ating. Section L (Oral/Dental vas coded as having no eth and no dental concerns. eted by the Registered					
	Resident #2's care pa include any oral or de	an dated 5/1/18 did not ental concerns.					
		8/6/18 at 4:44 PM, Resident a broken upper right front					
	(SW) stated the facilit #2's "chipped tooth" of in-house Dentist saw stated the in-house D	her on 6/22/18. The SW Dentist was scheduled to nce the Responsible Party					
	completed Section L	t 3:15 PM, the RD stated she of Resident #2's admission accurately and it was simply					

If continuation sheet Page 20 of 81

	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION		D. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED
						С
		345534	B. WING			/09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			:	2702 FARRELL ROAD		
SANFUR	D HEALTH & REHABILIT	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 641	Continued From page	e 20	F 641			
		art. She confirmed she				
		ervation of Resident #2's				
	teeth but did not note	e the broken front tooth.				
	Interview on 9/0/19 a	t 4:10 DM the Administrator				
		t 4:10 PM, the Administrator ectation that the MDS be an				
		Resident #2's oral/dental				
		ould have coded Section L				
		S dated 5/1/18 accurately.				
F 656		Comprehensive Care Plan	F 656	3		9/5/18
SS=D	CFR(s): 483.21(b)(1)					
	§483.21(b) Compreh	ensive Care Plans				
		cility must develop and				
		nensive person-centered				
		sident, consistent with the				
	-	th at §483.10(c)(2) and				
	§483.10(c)(3), that in	ames to meet a resident's				
	1 -	d mental and psychosocial				
		fied in the comprehensive				
		nprehensive care plan must				
	describe the following					
		are to be furnished to attain ent's highest practicable				
		l psychosocial well-being as				
		24, §483.25 or §483.40; and				
	(ii) Any services that	would otherwise be required				
		.25 or §483.40 but are not				
	-	esident's exercise of rights				
	treatment under §483	ding the right to refuse 3.10(c)(6).				
	-	ervices or specialized				
	rehabilitative services	s the nursing facility will				
	provide as a result of					
		a facility disagrees with the				
	rationale in the PASA	RR, it must indicate its				
						1

Facility ID: 20050005

If continuation sheet Page 21 of 81

		ND HUMAN SERVICES MEDICAID SERVICES				FORM): 09/04/20 [,] /I APPROVE). 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		SURVEY PLETED
		345534	B. WING _				09/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SANFOR	HEALTH & REHABILIT			27	702 FARRELL ROAD		
				S	ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From pag	e 21	F	556			
	(iv)In consultation with	th the resident and the		/00			
	resident's representa						
	desired outcomes.	als for admission and					
	(B) The resident's pre	eference and potential for					
		cilities must document					
(s desire to return to the seed and any referrals to					
		es and/or other appropriate					
	entities, for this purpo	ose.					
		in the comprehensive care					
		in accordance with the h in paragraph (c) of this					
	section.						
	This REQUIREMEN	Γ is not met as evidenced					
	by:					•	
		ons, staff interviews and cility failed to develop a care			The facility failed to develop a care pl for Resident #31 related to contracture		
		#31) of 3 residents reviewed			The facility failed to develop a care pla		
		facility also failed to develop			for Resident #90 related to unplanned		
		d weight loss. This was for 1			weight loss.		
	(Resident #90) of 4 r	esidents reviewed for			Resident #31 has a right-hand		
		s included.			contracture. Resident #31 was discha	rged	
	1. Resident #31 was	admitted on 3/8/12 with			to the hospital on 4/15/18 and readmin		
		s of Cerebral Vascular			to the facility on 4/22/18. Upon		
	Accident, Diabetes a	nd right-side hemiplegia.			readmission, the previous splint order not re-activated nor was an order rece		
	Review of Resident #	#31's Physician orders			for splinting. Review of medical record		
		ted 10/5/17 which read he			and physician orders did not notate th	ie	
		d resting splint for 4 hours			contracture and therefore the contract	ure	
	daily.				was not reflected on the care plan. Resident #90 experienced an unplanr	led	
	His Significant Chan	ge Minimum Data Set (MDS)			weight loss. The Dietary Manager faile		
	dated 6/17/18 indicat	ed severe cognitive			initiate a care plan addressing weight	loss	
		xhibited behaviors. He was			as she is new to her role and was uns	sure	
	coded for impairmen	t to one upper extremity.			of what to put in the care plan.		
	Review of Resident #	#31 latest care plan revised			Resident #31's Care Plan was update	d on	
	1	-			•		1

Facility ID: 20050005

If continuation sheet Page 22 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/04/201 1 APPROVEI 0. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	LETED
		345534	B. WING			08/0	。 09/2018
NAME OF PI	ROVIDER OR SUPPLIER	l		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SANFORD	HEALTH & REHABILIT	ATION CO			702 FARRELL ROAD		
				S	ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From page	2.22		656			
1 000		le a care plan for splinting of		000	8/9/18 to reflect a risk for decreased F		
	his right-hand contract				due to right hand contracture.		
	During an observation Resident #31 was sitt was observed with a			Resident #90's Care Plan was update the Dietary Manager on 8/8/18 to refle significant weight loss.	-		
	Resident #31 was sitt	ion on 8/7/18 at 3:40 PM, ting up in his wheelchair. He right-hand contracture.			An audit was initiated by the MDS Coordinator on 8/23/18 to ensure that each resident has an accurate		
		/18 at 3:55 PM, the MDS urately coded the Significant			comprehensive person-centered care plan. Members of the Interdisciplinary Team assisted in the audit following		
		6/17/18 to reflect impairment			re-education on 8/23/18. All active		
		y. She stated she reviewed			residents current care plan was audite	ed	
		al record and readmission			for accuracy between 8/23/18 and		
	orders but did not rea				8/24/18. Of 105 care plans audited, 1	5	
		to his right-hand contracture			residents care plans were updated to		
	so she neglected to c	are plan his contracture.			reflect existing contractures and 18 residents care plans were updated to		
					reflect an edentulous state or other de	ntal	
	The facility provided a	a care plan dated 8/9/18 for			issue.	inter	
		hand contracture with the					
	intervention of splintir	ng as ordered.			The Interdisciplinary Team, including to Dietary Manager and MDS Coordinate		
	In an interview on 8/9				were in-serviced by the Corporate Nu	rse	
		t was her expectation that at			Consultant on 8/23/18 regarding		
		#31's Significant Change			developing appropriate and accurate comprehensive person-centered care		
	right-hand contracture	e would have noted his e and care planned			plans for each resident.		
	previously ordered in	-					
					In order to provide Quality Assurance		
					utilizing a Care Plan quality assurance		
					Audit tool the MDS Coordinator will re		
					care plan accuracy on five residents p		
		admitted to the facility on			week for 4 weeks and then five reside		
		nitted on 4/30/18 with cluding dementia with			per month for an additional two month	5.	
	behaviors.	Graning dementia with			The MDS Coordinator will present the		
	7(02-99) Previous Versions Obs	solete Event ID: S6K(-		sility ID: 20050005		

Facility ID: 20050005

If continuation sheet Page 23 of 81

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/04/2018 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345534	B. WING				C / 09/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SANFORD	HEALTH & REHABILIT	ATION CO		2	702 FARRELL ROAD		
	neaenn a Renableni			S	SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From page 23		F	656			
	(MDS) assessment d Resident #90 had sev and had a significant months.	e in Minimum Data Set ated 7/20/18 indicated that vere cognitive impairment weight loss in the last 6			results of these audits to the Quality Assurance Performance Improvemen Committee for a minimum of three consecutive meetings to identify trend concerns, and recommendations for a modification of the process.	ls, any	
	for Nutrition was revie that nutrition was trigg Resident #90 was on	esment (CAA) dated 7/20/18 ewed. The CAA revealed gered due to weight loss. mechanical soft diet with He required assistance with d to care.			The Administrator will be responsible the plan of correction.	for	
	7/19/18 revealed that	90's current care plan dated there was no care plan proaches developed for ss.					
	was interviewed. She DM 5 weeks ago and do care planning. She do the care plan for w	I, the Dietary Manager (DM) e stated that she started as I she was still learning how to e confirmed that she didn't veight loss for Resident #90 now what to put in the care					
	On 8/8/18 at 4:39 PM, the Registered Dietician (RD) was interviewed. She stated that the DM was responsible for developing the care plans. The RD verified that Resident #90 had a significant weight loss and a care plan should have been developed. She added that the DM was new and she was still learning the care plan process.	 She stated that the DM leveloping the care plans. Resident #90 had a s and a care plan should She added that the DM 					
	interviewed. She sta	l, the MDS Nurse was ted that the DM was oping the care plan for					

If continuation sheet Page 24 of 81

				E CONSTRUCTION	OMB NO. 0938	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345534	B. WING		C 08/09/201	18
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SANFOR	HEALTH & REHABILIT	ATION CO		2702 FARRELL ROAD		
0,111 0112				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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMP	X5) PLETION ATE
F 656	Continued From page	e 24	F 65	6		
	nutrition.			-		
		I, the Administrator and the				
		ere interviewed. The that she expected a care				
	plan developed when care plan.	CAA indicated to proceed to				
F 677	-	or Dependent Residents	F 67	7	9/5/18	8
SS=D	CFR(s): 483.24(a)(2)					
		lent who is unable to carry				
		living receives the necessary good nutrition, grooming, and				
	personal and oral hyg					
	This REQUIREMENT	「 is not met as evidenced				
	Based on observatio	ons, staff interviews and		Resident #31 was observed with a		
	nail care (Resident #3	cility failed to provide routine 31) for 1 of 3 sampled		right-hand contracture with long, jag untrimmed fingernails.	iged,	
	residents who were d	es of daily living (ADL).		Direct care staff failed to assess		
	The findings included			resident's nails and provide necessa services to maintain grooming of na		
		mitted on 3/8/12 with		Desident #24/a firstern tils og fi	una a d	
		s of Cerebral Vascular nd right-side hemiplegia.		Resident #31's fingernails were trim and filed on August 8, 2018 by the licensed nurse assigned to the resid		
	Resident #31's care p	plan dated 6/15/18 indicated				
		m with all his activities of		Administrative nursing staff complet		
	daily living (ADLs).			100% audit of all resident's nails in facility on August 17, 2018. At the ti		
	His Significant Chang	ge Minimum Data Set dated		assessment, 18 residents were ider		
	6/17/18 indicated sev	vere cognitive impairment		with have long, jagged, or untrimme	d	
		aviors. He was coded for		nails. These residents nails were cle	eaned,	
		ance with hygiene and for a o one upper extremity.		trimmed, and filed at the time of assessment by licensed nursing sta	ff and	
		s one upper extremity.		certified nursing assistants. For resi		
	During an observation	n on 8/6/18 at 11:42,		who prefer to have long nails, care		

Facility ID: 20050005

If continuation sheet Page 25 of 81

OLIVIER		MEDICAID SERVICES				NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
	CONTECTION		A. BUILDING	i		
		345534	B. WING			C
		545554		STREET ADDRESS, CITY, STATE, ZIP CO		8/09/2018
NAME OF P	ROVIDER OR SUPPLIER			2702 FARRELL ROAD		
SANFORD	HEALTH & REHABILIT	ATION CO		SANFORD, NC 27330		
o				·		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 677	Continued From page	e 25	F 67	7		
		ting up in his wheelchair. He		were updated on to reflect re	esident	
		right-hand contracture with		preference.		
		ed finger nails. His left-hand				
	fingernails were trimn	ned and filed.		The Administrator provided		
				to all Administrative Staff on	-	
		ion on 8/7/18 at 3:40 PM,		2018 regarding daily room r		
		ting up in his wheelchair. He		assessment of resident's na		
	long, jagged untrimm	right-hand contracture with		in-service included assessin residents with contractures.		
				hired administrative staff wil	-	
	In a third observation	on 8/8/18 at 8:40 AM,		appropriate education during		
		served in bed eating his		Staff will not be allowed to w	-	
		served with a right-hand		have received the in-service	•	
	fingernails.			The Assistant Director of Nu	rsing initiated	
				an in-service to all nurses a	nd nursing	
		3/18 at 8:40 AM, Nurse #1		assistants on August 20, 20		
		t #31 was Diabetic, the		care of fingernails and toena		
	nurses were respons			in-service included assessin	•	
	-	d she was not aware his		residents with contractures.		
	fingernails on his righ			nurse will be responsible for	-	
		he aides on the floor should		residents nails for those res		
	right-hand fingernails	her, but she would trim his		diagnosis of diabetes. All ne nurses and nursing assistan	-	
				the appropriate education d		
	In an interview on 8/8	3/18 at 12:00 PM, Nursing		orientation. Staff will not be		
		ited the aides were not		work until they have receive		
	allowed to trim the fin			in-service.		
		she did not notice the long				
	-	nt #31's right-hand because		To ensure quality assurance	-	
	of his contracture.			room round audit sheet, adr		
	la a final al consti			staff will audit 100% of resid		
		on 8/9/18 at 8:50 AM.		fingernails 3 times weekly x		
	trimmed and filed.	nails to his right hand were		twice weekly x 2 months. R these audits will be discusse		
				Stand-up meeting with any i		
	In an interview on 8/9)/18 at 4 [.] 10 PM_the		reported to the Director of N		
		it was her expectation that		Assistant Director of Nursing	-	
		the fingernails of all Diabetic		Stand-up meeting is manda		

Event ID: S6KG11

Facility ID: 20050005

If continuation sheet Page 26 of 81

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
					С	
		345534	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	08/09/2018	
NAME OF P	ROVIDER OR SUPPLIER					
SANFOR	DHEALTH & REHABILITA	ATION CO		2702 FARRELL ROAD SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETI		
F 677		it was her expectation that ed Resident #31's fingernails	F 67'	 administrative staff, including the Dire of Nursing, Assistant Director of Nurse Unit Managers x2, treatment nurse, Central Supply Coordinator, HR/Payr Director, Social Services Director, MI Coordinator, Plant Operations Director Activities Director, Admission Coordin Business Office Manager, Administrate Environmental Services Director, and Medical Records Director. The Administrator will present the rest of these audits to the Quality Assurar Performance Improvement Committee 	sing, roll DS or, nator, ator, d sults nce	
F 686 SS=D	CFR(s): 483.25(b)(1) §483.25(b) Skin Integ	ırity	F 68	a minimum of three consecutive mee to identify trends, concerns, and recommendations for any modificatio the process. The Administrator will be responsible implementing the plan of correction.	tings n of	
	resident, the facility m (i) A resident receives professional standard pressure ulcers and o ulcers unless the indi demonstrates that the (ii) A resident with pre- necessary treatment with professional star	chensive assessment of a hust ensure that- is care, consistent with is of practice, to prevent does not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent indards of practice, to vent infection and prevent				

Facility ID: 20050005

If continuation sheet Page 27 of 81

	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MEILTIPE	E CONSTRUCTION		<u>D. 0938-03</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
		345534	B. WING		08	C / 09/2018
NAME OF PR	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP COD	E	
	HEALTH & REHABILIT		2	2702 FARRELL ROAD		
			5	SANFORD, NC 27330		
(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)	SHOULD BE	(X5) COMPLETIO DATE
F 686	Continued From pag		F 686			
	This REQUIREMEN ⁻ by:	Γ is not met as evidenced				
		iew, observation and Wound		The facility failed to provide p		
		istered Dietician (RD) and		measures to prevent pressure		
	staff interview, the fa			development to Resident #90		
	•	es to prevent pressure ulcer sident who was at risk for		risk for pressure ulcers resulti development of 4 additional p	•	
		resulted to the development		ulcers.		
	•	ure ulcers for 1 of 3 sampled				
		or pressure ulcer (Resident		Resident #90 readmitted to th	e facility on	
	#90).			4/30/18 with a stage 2 commu	•	
				acquired pressure ulcer to his		
	Findings included:			5/30/18, an unstageable pres		
				was identified on the resident		
		iginally admitted to the facility admitted on 4/30/18 with		stage 2 pressure ulcer was id		
		icluding dementia and		the perineum, and the stage 2 ulcer on the resident's sacrun		
	peripheral vascular d			determined to be deteriorating		
				7/18/18, the resident's Album	•	
	The quarterly Minimu	ım Data Set (MDS)		2.8 and the resident started o		
		8/18 indicated that Resident		Prostat was discontinued on 7	7/25/18	
	#90 had impaired co	gnition, needed extensive		because the resident was on	thickened	
	-	ons for bed mobility, was		liquids. Resident #90 was ref		
	-	bowel and bladder and had		wound care specialist on 7/25		
		he assessment further		air mattress was applied to th	e resident's	
	indicated that Reside developing pressure			bed.		
	developing pressure			The facility failed to provide p	reventative	
	The 5 day MDS asse	essment dated 5/7/18		measures, including nutritiona		
	indicated that Reside			supplements to promote would		
		tensive assistance of 2		and pressure relieving device	-	
	•	ility, was always incontinent		resident's bed and chair, to p		
		and was admitted with a		pressure ulcer development f	or Resident	
		er. The assessment further		#90.		
	indicated that Reside					
	developing pressure	uicer.		On 7/19/18 Resident #90 was		
		ssessment dated 7/4/18		planned to receive a high pro- snacks in between meals. Re		
	THE HURDERVINUS A	SCASSINALI NATAN NATIX	1			1

Facility ID: 20050005

If continuation sheet Page 28 of 81

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	(X3) DATE SURVE	8-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED	
					С	
		345534	B. WING		08/09/20	18
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
SANEODI	HEALTH & REHABILIT			2702 FARRELL ROAD		
SANFORL				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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COMP HE APPROPRIATE D	(X5) PLETIC DATE
F 686	Continued From page	e 28	F 68	36		
		tensive assistance of 2		specialist and provided an a	alternating air	
	•	ility, was always incontinent		mattress and pressure relie		
	of bowel and bladder			on 7/25/18. Care plan meet	ing was held	
		sue injury (DTI) pressure		with the resident's family on		
	ulcer that was not pre	esent on admission.		discuss PEG placement and	-	
	The significant change			Care. Resident's Responsit		
	The significant chang	20/18 revealed that Resident		Representative and family r and Hospice at this time. Re		
		gnition, needed extensive		was assessed by the dietici		
		ons for bed mobility, was		with new orders received fo		
	-	bowel and bladder and had		and zinc sulfate. Resident #		
		e with eschar pressure ulcers		reassessed by the attending		
	and two (2) unstagea	ble/deep tissue injury (DTI)		8/23/18 with orders received	d to initiate	
	pressure ulcers that v admission.	were not present on		magic cup to promote wour Resident #90 will continue t	o be assessed	
				weekly by the dietician and		
	(normal value 3.6-5.1	t #90's albumin level was 2.8).		specialist. Resident #90 will weekly in the patients at ris		
		plan dated 7/19/18 was		On 8/16/18 and 8/17/18 a 1		
		olan approaches included		was initiated by the Treatme		
		ot as ordered, wound doctor		Director of Nursing, Assista		
		as indicated and on 7/25/18		Nursing, and Unit Managers		
		added. The approaches did ning schedule or pressure		residents to identify any new skin concerns. Three reside		
	relief device when ou			identified with excoriation, 1		
				identified with a skin tear, 6		
	-	s wound assessment was		were identified with existing		
		essments revealed the		residents were identified to		
	following:			discoloration, 7 residents w		
	5/1/19 atags 2 pres	sure ulear on aperum		to have skin redness, 2 resi		
	identified on admission	sure ulcer on sacrum - on (4/30/18)		identified with dry skin, 2 re identified with scratches, an		
				were identified with facility a		
	5/30/18 - unstageable	e/DTI on lateral left heel -		pressure ulcers. Any reside		
	developed in house			to have new skin concerns	were referred	
				to the treatment nurse at the		
		e to left great toe due to		identification for immediate	assessment	
	slough/eschar - deve	loped in house		and intervention.		

Facility ID: 20050005

If continuation sheet Page 29 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/04/2018 APPROVED D: 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION		SURVEY LETED
		345534	B. WING				09/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SANFORD) HEALTH & REHABILITA	ATION CO			702 FARRELL ROAD ANFORD, NC 27330		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 686	Continued From page	29	F	586			
	left buttock- develope	e due to slough/eschar on d in house e/DTI to left medial heel -			On 8/21/18 100% of resident's receive Braden Scale Assessment completed the treatment nurse. At this time, 4 residents were identified as moderate for pressure ulcer development and preventative interventions were	by risk	
	Resident #90's doctor's orders were reviewed. 5/2/18 - prostat (protein supplement) 30 milliliter daily for wound healing and was increased to twice a day on 7/18/18 and was discontinued on 7/25/18.				implemented; three residents received air mattress, one resident received an order for heel protectors, and one resid received an order for nutritional supplementation. All residents with current pressure ulco were audited by the treatment nurse o	dent ers	
	shoes to left foot	s to left foot at all times, no soft with nectar thick liquids			8/21/18 and 8/22/18 to ensure appropriate interventions are in place to prevent worsening of current pressure ulcers. A result of this audit, one resident was placed on an air mattress and one resident was referred to the dietician a	riate As a	
	specialist on 7/25/18. the resident had pres- with yellow necrotic ti- heel (DTI), Left media with yellow necrotic ti- buttock/ischium with y	erred to a wound care The notes revealed that sure ulcers on the sacrum ssue (stage 2), left lateral al heel (DTI), left great toe ssue (unstageable) and left yellow necrotic tissue (stage tion was to acquire an air			orders received for nutritional supplementation. 100% of Care Plans were audited by the interdisciplinary te on 8/23/18 and 8/24/18 to ensure appropriate interventions are care plan to prevent pressure ulcer development with one care plan updated to include air mattress and one care plan update include nutritional supplementation to prevent wound deterioration/development	eam nned t an d to	
	He had no pressure r On 8/8/18 at 3:05 PM observed during the c	a chair in the dining room. elieving device in his chair. , Resident #90 was dressing change. The assessed by the wound			of new wounds. The treatment nurse or weekend supervisor will notify the Physician and Dietician when a nutritional problem, including development of pressure ulc has been identified and shall collabora with the Dietician and Physician to initi	d ers, ate	

Event ID: S6KG11

Facility ID: 20050005

If continuation sheet Page 30 of 81

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/04/2 FORM APPRO OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345534	B. WING		C 08/09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			:	2702 FARRELL ROAD	
SANFORD HEALTH & REHABILITATION 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLET
F 686	Continued From page	e 30	F 686		
		0.00	1 000		
	dressing change.			an appropriate process of clini for causes of the nutritional pro	
	The left lateral heel p	ressure ulcer was observed			
		ze with no drainage noted.		The treatment nurse or weeke	
		as cleaned with wound		supervisor will complete a Bra	
	cleanser and betadin	e was applied.		assessment on each resident	
	The left medial heel r	pressure ulcer was observed		admission or re-admission, we weeks post admission, and the	
		rainage noted. The ulcer		or with any significant change	
		und cleanser and betadine		Any resident identified at mode	
	was applied.			risk for developing pressure ul	-
				have appropriate preventative	
		sure ulcer was observed with		interventions initiated at time of	f
	yellow eschar center			assessment.	
	-	ulcer was cleaned with			
	wound cleanser and	zinc oxide was applied.		Each resident with an existing	
	The sacral pressure i	ulcer had no eschar nor		ulcer will be discussed weekly interdisciplinary team, includin	
		ulcer was cleaned with		Dietician and treatment nurse,	
		calcium alginate was applied		patients at risk meeting to dete	
	and covered with foa			needed changes in plan of car	-
	The left great toe pre	ssure ulcer was black and		The Dietician was issued a 30-	-day
	dry. It was cleaned v	vith wound cleanser and skin		termination of contract notice of	-
	prep was applied.			and a contract was signed to in	
	0-0/0/40 40.00			services with a different dieticia	an.
		1, the wound care specialist		The Appintent Director of Name	ing initiated
		e stated that Resident #90 n 7/25/18 and she had seen		The Assistant Director of Nursi an in-service on 8/24/18 to all	•
		en. The resident was at risk		nursing staff regarding prevent	
	of developing pressu			pressure ulcers. This in-service	
		resident was not on any		identifying factors that place a	
	pressure relieving de	vice in bed and on the chair		high risk of pressure ulcers, i.e	. .,
		r mattress for him. She also		immobility, inadequate nutrition	
	recommended a dieta	ary consult.		co-morbidities. This in-service	
				included examples of appropri	
		1, the Registered Dietician		interventions to help reduce th	
		 She stated that she was umin level but she had to 		pressure ulcer development in frequent repositioning, use of t	
	aware of the low alot				

Facility ID: 20050005

If continuation sheet Page 31 of 81

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/04/20 FORM APPROV OMB NO. 0938-03
TATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345534	B. WING		C 08/09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
				2702 FARRELL ROAD	
SANFORD HEALTH & REHABILITATION 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 686	Continued From page	o 31	F 68	e	
1 000			F 00		
		at because Resident #90 quids and prostat could not		creams, request for nutrition supplementation, monitori	
		asked what was added to		appropriate labs, etc. All n	
		he RD stated that she didn't		licensed nursing staff will r	
		med pass. The RD further		appropriate education upo	
		nt was expected to lose		Employees will not work u	
	weight due to demen	-		received the appropriate e	ducation.
	On 8/9/18 at 9:50 AM	1, Nurse #3, Treatment		The Director of Nursing ini	
		ed. She stated that she		in-service to the treatment	
		Nurse a week or so ago.		weekend supervisor on 8/2	
		e previous treatment nurse		included completion of Bra	
		work. She indicated that		all residents upon admissi	
		he resident's pressure ulcers rred him to the wound care		re-admission, weekly for 4 admission and quarterly th	
	-	ed that the resident was not		in-service included implem	
		elieving devices in bed and		measures to prevent press	•
		when the wound care		development for any resid	
	specialist recommend			be at moderate or high risl	
				ulcer development. All nev	-
	On 8/9/18 at 3:05 PM	1, NA #3 was interviewed.		treatment nurses and wee	kend
	She stated that reside			supervisors will receive the	e appropriate
	· ·	Ind provided incontinent care rounds including Resident		education during orientation	on.
	#90.	-		The Director of Nursing pr	ovided an
				in-service to the treatment	nurse on
		1, the Administrator and		8/24/18 that included treat	
		DON) were interviewed. The		roles and responsibilities a	5
		that she had 4 changes in		attendance in weekly patie	
	Treatment Nurse since			meetings. All newly hired t	
		acility in February 2018.		nurses will receive the app	•
	She revealed that Nu	oring the pressure ulcers to		education during orientation	л.
	ensure interventions			To ensure quality assurance	ce utilizing a
		nent of pressure ulcers. She		Pressure Ulcer audit tool,	
		expected pressure relieving		Nursing will audit all reside	
		repositioning schedule as		pressure ulcers to ensure	
	-	re of residents who were at		interventions are in place	
		tor added that the RD should		deterioration of pressure u	

Facility ID: 20050005

If continuation sheet Page 32 of 81

ATEMENT (OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		0.0000	B. WING		с	
		345534	B. WING		08/09/2018	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SANFORD	HEALTH & REHABIL	ITATION CO		2702 FARRELL ROAD		
				SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTIO	
F 686	Continued From pa	•	F 68			
	have tried other protein supplement to replace the prostat to help with the wound healing and low albumin level.			development of new pressure ulce This audit will be completed weekl weeks, then monthly for 2 months. Administrator will review the audit weekly x 4 weeks, then monthly x for trends and concerns.	y x 4 The tools	
				To ensure quality assurance, utiliz Braden Scale Audit tool, the Direct Nursing will audit all residents to e that a Braden Scale has been com upon admission/re-admission, wee post admission, with any significar change, and quarterly. This audit w include ensuring residents with a moderate to high risk of developm pressure ulcers have appropriate preventative interventions in place of identification of such risk. This a be completed weekly x 4 weeks, th monthly for 2 months. The Adminis will review the audit tools weekly x weeks, then monthly x 2 month for and concerns.	tor of nsure npleted ekly x 4 nt will ent of at time audit will nen strator 4	
				The Director of Nursing will preser results of these audits to the Quali Assurance Performance Improven Committee for a minimum of three consecutive meetings to identify the concerns, and recommendations for modification of the process. The Director of Nursing will be responsible for implementing the p	ty nent ends, or any	
F 688 SS=D	Increase/Prevent D CFR(s): 483.25(c)(ecrease in ROM/Mobility	F 68	correction.	9/5/18	

Facility ID: 20050005

If continuation sheet Page 33 of 81

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/04/20 FORM APPROVI OMB NO. 0938-03
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345534	B. WING		C 08/09/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SANEODE	HEALTH & REHABILIT		:	2702 FARRELL ROAD	
				SANFORD, NC 27330	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
F 688	Continued From page	e 33	F 688		
	resident who enters t range of motion does range of motion unles condition demonstrat of motion is unavoida §483.25(c)(2) A resid motion receives appr services to increase n prevent further decre §483.25(c)(3) A resid receives appropriate assistance to maintai the maximum practice reduction in mobility i	cility must ensure that a he facility without limited a not experience reduction in as the resident's clinical es that a reduction in range able; and lent with limited range of opriate treatment and range of motion and/or to ase in range of motion. lent with limited mobility services, equipment, and n or improve mobility with able independence unless a s demonstrably unavoidable. T is not met as evidenced			
	and staff interviews a failed to apply splintin management (Reside transcribe and to app recommended by the correctly (Resident # Resident #11) of 3 sa for range of motion. 1. Resident #31 was cumulative diagnoses Accident, Diabetes an Review of Resident # included an order dat	ly the splints as		The facility failed to apply splinting devices for contracture manageme Resident #31 and failed to transcri to apply splints as recommended to therapy department correctly for R #31 and Resident #11. Resident #31 was discharged to the hospital on 4/15/18 and readmitted facility on 4/22/18. Upon readmissis previous splint order was not re-ad- nor was an order received for splin On 4/23/18 there was an order for to apply left upper extremity resting splint and remove after 4-6 hours of the night for Resident #11. This ord transcribed to the MAR and initiale	ent for be and by the esident to the to the tivated tting. nursing g hand during der was

Facility ID: 20050005

If continuation sheet Page 34 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/04/2018 // APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345534	B. WING				C 09/2018
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
SANEORD				27	02 FARRELL ROAD		
JANFORD	SANFORD HEALTH & REHABILITATION CO			S	ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Continued From page	e 34	Fe	886			
	Review of Resident # Administration Record 4/14/18, read the num his resting right-hand Review of Resident # orders read that the of was discontinued on hospitalization. Review of Resident # indicated he was read 4/22/18, then dischar 6/6/18 with readmission Hospice. His Significant Chang 6/17/18 indicated sev with no exhibited beh impairment to one up Review of Resident # 6/22/18 did not includ his right-hand contrad Review of Resident # dated 7/26/18 read hor right upper extremity. Review of Resident # May, June, July and / an order for his restin applied 4 hours daily. Review of Resident #	 31's Medication d (MARs) from 10/6/17 to ses initialed off that he wore splint 4 hours daily. 31's April 2018 Physician order for his right-hand splint 4/15/18 due to 31's medical record dmitted to the facility on ged back to the hospital on on to the facility on 6/10/18 ge Minimum Data Set dated rere cognitive impairment aviors. He was coded for per extremity. 31 latest care plan revised le a care plan for splinting of cture. 31's Resident Care Guide e was to wear a splint to his 31's Physician orders for August 2018 did not include ig right-hand splint to be 			nursing staff; however, the contracture was present on the right hand. Althour nursing staff report they were applying splint to the right hand, the order for the left upper extremity hand splint was no clarified by nursing staff to reflect the correct extremity. On 6/6/18 there was order for right elbow splint for Resider #11 that was never transcribed to the MAR. Resident #31 was re-assessed by the therapy department on 8/10/18 and an order was received for a resting hand splint to be applied to the right hand during the day for up to 8 hours as tolerated and for a left hand 3rd-4th dis splint to be applied at night for up to 8 hours as tolerated. Resident #11 was assessed by the therapy department on 8/8/18. A clarification order was received on 8/8 for Resident #11 to have a right restin hand splint applied for up to 8 hours as tolerated. An order was transcribed for Resident #11 to have a right elbow sp applied nightly for up to 8 hours as tolerated.	gh g the he ot s an ht n igit y/18 g s r lint 18 g, ent e	
		n on 8/6/18 at 11:42 AM,			management are accurate and transcribed accurately on the MAR. N	ine	

Facility ID: 20050005

If continuation sheet Page 35 of 81

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/04/201 M APPROVE O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345534	B. WING				C / 09/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
SANFORD	HEALTH & REHABILIT	ATION CO			702 FARRELL ROAD ANFORD, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Continued From page	- 35	F 6	88			
		ting up in his wheelchair. He		00	residents were identified to be on		
		right-hand contracture. He			restorative nursing services for		
	was not wearing a rig	•			contracture management; however, n	`	
	was not wearing a ng				order was present for contracture	0	
	In a second observat	ion on 8/7/18 at 3:40 PM,			management. The therapy department	t	
		ting up in his wheelchair. He			wrote clarification orders for these nin		
		right-hand contracture and			residents on 8/24/18 after evaluation.	Six	
	not wearing a right-ha	and splint.			residents were identified with contract	ures	
					present but were not receiving service	s	
		3/18 at 8:40 AM, Nurse #1			for contracture management. These		
		had previously worn a			residents were referred to the therapy		
		nurse ensured it was			department for evaluation of contractu	ire	
		nd it would be removed after staff. She stated she had			management on 8/22/18.		
		hand splint in a few months			The therapist making a recommendat	ion	
		nger on his MAR. Nurse #1			for contracture management will obtai		
	stated she assumed i				order from the resident's attending	in an	
					physician. The order will be provided t	0	
	In an interview on 8/8	8/18 at 12:00 PM, Nursing			the staff nurse to implement. Copies of		
		ted Resident #31 used to			orders will be provided to the unit		
	wear a right-hand spl	int but she had not seen him			managers or weekend supervisor dail	y to	
	wearing a splint in se normally he wore it in	veral months. She stated he a the evenings.			review for accuracy.		
					All medical records of residents		
	In an interview on 8/8				readmitted to the facility will be review	ed	
		or stated the Occupational			on the day of readmission by the Unit		
	Therapist performed				Manager to ensure that any previous		
		ted no significant change in			splinting orders are clarified if needed		
	-	cture as of 8/8/18. She ere written on 8/8/18 for			processed, and transcribed accurately		
		his resting right-hand splint			An in-service was initiated by the		
		4 hours as tolerated. The			Assistant Director of Nursing on Augu	st	
	-	or stated Resident #31's			21, 2018 to all licensed nursing staff		
		int should have been			regarding accurate processing and		
		spitalization in April 2018.			transcription of orders. This in-service		
					included discussion of clarifying order		
	In an interview on 8/9	9/18 at 3:30 PM, NA #1			necessary in regards to splinting of		
		used to wear a right-hand			appropriate extremities. All newly hire	d	
		ot seen him wearing it for			licensed nursing staff will receive this		

Facility ID: 20050005

If continuation sheet Page 36 of 81

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/04/2018 M APPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345534	B. WING				C / 09/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SANFOR	HEALTH & REHABILIT	ATION CO		27	702 FARRELL ROAD		
	nezem a kenzbiem			S	ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	several months. She splint was discontinue Hospice. In an interview on 8/S Administrator stated right-hand splint was admitted to the hospi apparently was not re MAR after hospitaliza expectation that orde right-hand splint were readmission to the fa splint be applied daily 2. Resident # 11 was facility on 2/17/17 and with multiple diagnos hemiplegia affecting fa annual Minimum Data dated 5/7/18 indicate memory and decision limitation in range of restorative nursing pr (active or passive) or the last 7 days. Resident #11's care pr reviewed. One of the contracture of the rig with range of motion extremities. The app be applied as ordered Resident #11's docto On 4/23/18, there wa apply left upper extremities	stated maybe the right-hand ed when he went on 2/18 at 4:10 PM, the Resident #31's resting discontinued when he was tal on 4/15/18 and it esumed and added to the ation. She stated it was her ors to resume his resting e obtained after his cility on 4/22/18 and the y. • originally admitted to the d was readmitted on 4/23/18 es including spastic right dominant side. The a Set (MDS) assessment d that Resident #11 had n making problems, had motion and did not receive rograms for range of motion • splint or brace application in • plan dated 5/7/18 was e care plan problems was ht upper extremity (RUE) (ROM) deficits to all four rroaches included splints to d. r's orders were reviewed. is an order for nursing to emity resting hand splint and	F	588	education upon orientation. No staff w work until completion of in-service. In order to provide Quality Assurance utilizing a Contracture Management quality assurance audit tool the Direct Nursing will audit all new orders recei for contracture management weekly five weeks, then monthly for 2 months to ensure appropriateness of order and accurate processing and transcription the order. The Director of Nursing will present the results of these audits to the Quality Assurance Performance Improvemen Committee for a minimum of three consecutive meetings to identify trend concerns, and recommendations for a modification of the process. The Director of Nursing will be responsible for implementing the plan correction.	, ved or 4 of t ls, any	
	reviewed. One of the contracture of the right with range of motion extremities. The app be applied as ordered Resident #11's docto On 4/23/18, there wa apply left upper extre remove after 4-6 hou AM and off at 6:30 Al	e care plan problems was ht upper extremity (RUE) (ROM) deficits to all four roaches included splints to d. r's orders were reviewed. is an order for nursing to			-10-20050005 Kranski		

If continuation sheet Page 37 of 81

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/04/2018 APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				LETED
		345534	B. WING		_		C 09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SANFOR) HEALTH & REHABILITA	TION CO		2702 FARRELL ROAD SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 688	order for right elbow s sleep and remove due The Medication Admin for June, July and Aug The order for the left of splint was transcribed initialed by the nurses applied as ordered. T splint was not transcri On 8/8/18 at 2:50 PM interviewed. She stat Resident #11. She in nurse was responsible splint. NA #7 reveale Resident #11 wearing Monday morning of 8. didn't see any splint/b hand. On 8/9/18 at 2:37 PM She was assigned to She indicated that Re splint on his left hand indicated that she app hand for 4-6 hours at initialed the MAR. Sh #11 did not have an o splint. On 8/9/18 at 3:55 PM She stated that she w #11 on day shift. She an order for left hand She verified that the reside order for the right elbo verified that the reside	splint-wear at night during ring the day. histration Records (MARs) gust 2018 were reviewed. upper extremity resting hand to the MARs and was indicating that it was the order for the right elbow abed to the MARs. , Nurse Aide (NA) # 7 was red that she was assigned to dicated that the night shift e for the application of the d that she observed a splint on his left elbow (6/18. She stated that she race on his left or right , Nurse #6 was interviewed. Resident #11 on night shift. sident #11 had an order for at night. Nurse #6 further olied the splint to his left	F 68	8			

Facility ID: 20050005

If continuation sheet Page 38 of 81

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 09/04/2018 // APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345534	B. WING			_		C 09/2018
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
SANFORD	HEALTH & REHABILITA	TION CO			702 FARRELL ROAD ANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 688 F 689 SS=G	applied to the right ha On 8/9/18 at 3:56 PM was observed with Nu elbow splint observed There was no hand sp On 8/8/18 at 2:10 PM Director was interview provided the telephon splint dated 6/6/18 an know why it was not tu nursing. She also ver contracture on his righ hand. The Rehab Dir would let nursing know splints. She stated th follow the recommend application. On 8/9/18 at 4:07 PM Director of Nursing (D Administrator indicate contracture managem therapy department w implemented correctly Free of Accident Haza CFR(s): 483.25(d)(1)(0 §483.25(d) Accidents. The facility must ensu §483.25(d)(1) The res	ht had been clarified to be nd and right elbow. , the room of Resident #11 urse #1. There was an on top of the bedside table. blint observed. , the Rehabilitation (Rehab) ved. The Rehab Director e order for the right elbow d stated that she didn't ranscribed to the MAR by iffied that Resident #11 had ht hand and not the left ector indicated that she w to clarify the orders for the at she expected nursing to lation for the splint , the Administrator and the ON) were interviewed. The d that she expected that hent recommended by the ras transcribed and y by nursing. ards/Supervision/Devices 2)	F6					9/5/18
	§483.25(d)(2)Each re	sident receives adequate tance devices to prevent						

Event ID: S6KG11

Facility ID: 20050005

If continuation sheet Page 39 of 81

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/04/20 FORM APPROVE OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345534	B. WING		C 08/09/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
SANEODE	HEALTH & REHABILIT		2	2702 FARRELL ROAD	
SANFORL			5	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 689	Continued From page	- 39	F 689		
		is not met as evidenced	1 000		
	by:				
	-	iew, observation and staff		The facility failed to provide supervise	sion
		failed to provide supervision		to prevent Resident #57, who require	ed
		who required extensive		extensive assistance of 1 person for	
		on for toileting from having in the bathroom for one of		toileting, from having a fall in the bathroom.	
		ents reviewed for accidents.		bathoon.	
	·	enced an unsupervised fall in		Resident #57's Care Plan was last	
		stained a right femur fracture		updated on 4/4/18 and noted that the	e
	requiring open reduct	tion internal fixation (ORIF)		resident had impairment with mobility	/ and
	surgery (a surgical pr	ocedure to fix a severe		was 60% weight bearing as tolerated	I to
	broken bone).			the right lower extremity with a knee	
	Findings included:			immobilizer in place for all weight bea	aring.
	Findings included:			Resident #57 went to the bathroom unattended on 4/11/18. Nurse #3	
	Resident #57 was ori	ginally admitted to the facility		responded to an activated call light a	ind
		eadmitted on 2/5/18 with		observed Resident #57 on the toilet.	
	multiple diagnoses in	cluding dementia and right		Nurse #3 stepped from the bathroom	n to
	femur fracture.			the resident's room to obtain a brief	-
				the resident stood unassisted and fel	II
	The quarterly Minimu	. ,		sustaining a fracture.	
		2/18 indicated that Resident		Nurse #3 was unaware of the resider	ata
		ognitive impairment and sistance with one person		mental and weight bearing status wh	
		leting. The assessment		assisting resident when responding t	
		Resident #57 was not		call light and left the resident unatten	
		stabilize with staff assistance)		in the bathroom resulting in the resid	
	in moving on and off	toilet.		sustaining a fall.	
	The incident report d	ated 1/30/18 revealed that		Resident #57 was admitted to the ho	spital
		the bathroom unassisted		on 4/11/18 and underwent ORIF. Uni	it
		right proximal femur fracture.		Managers x 2 reviewed Resident #57	
	She went to the hosp readmitted on 2/5/18	ital for surgery and was		care plan and care guide on 8/22/18 ensure accuracy with no changes ma	
	-	dated 3/7/18 ordered for the		On 8/22/18 a fall risk assessment wa	
		weight bearing as tolerated		completed on 100% of residents by t	
	to right lower extremi	ty. The consult dated 4/4/18		Director of Nursing, Assistant Director	or of

Facility ID: 20050005

If continuation sheet Page 40 of 81

			0/02 100		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
			A. BUILDING	9	с
		345534	B. WING		08/09/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	
				2702 FARRELL ROAD	
SANFORL	HEALTH & REHABILIT	ATION CO		SANFORD, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DAT
F 689	Continued From pag	e 40	F 68	39	
		ent to have 60% weight	1.00	Nursing, and Unit Manag	ners v 2
	bearing with immobil	0		Ninety-two residents we	
	extremity			at high risk for falls. Resi	
				be at high risk for falls w	
	Resident #57's care	plan with the last review date		ensure appropriate fall ir	
	of 4/4/18 was review	ed. The care plan problems		place, care planned app	ropriately, and fall
	included resident had	d activities of daily living		interventions are accurate	tely reflected on
		it related to dementia with		the resident's care guide	۶.
		at risk for falls and fall			
	-	goal was to minimize		On 8/22/18 the past 90 c	-
		nt injury related to falls. The		were reviewed by the Di	
		60% weight bearing as er extremity and knee		Assistant Director of Nur Managers x 2, and MDS	-
		for all weight bearing. The		ensure appropriate fall ir	
	care plan did not add			accuracy of care plan an	
				residents sustaining a fa	-
	The nurse's notes (w	ritten by Nurse #1) dated		90 days were found to ha	
		evealed that Nurse #3 was		fall interventions in place	
	cleaning Resident #5	7 in the bathroom after		appropriately, and care g	guides reflecting
	having a bowel move	ement. Then, the Nurse sat		interventions.	
	the resident on the to	pilet and left the bathroom to			
	get a disposable brie			On 8/22/18 fall logs and	
		lurse #3 stepped out of the		were printed for each inc	
		lent's room, the resident		All intervention logs were	
	-	e resident complained of		ensure accuracy by the I	
		e and x-ray was ordered. wed fracture of the distal		Nursing, Assistant Direct and Unit Manager x 2. T	
		nt was sent to the hospital.		Nursing, Assistant Direct	
				and Unit Managers x 2 a	
	The hospital discharg	ge summary dated 4/16/18		resident's rooms to ensu	
		ident was admitted after		interventions are in place	
		ursing facility and sustained a		audit, one resident was f	-
	right distal femur frac	ture and underwent ORIF.		a fall mattress in the room	
				the audit, a fall mattress	-
	On 8/8/18 at 9:05 AM			resident's room. During	
		Ichair in her room. She was		resident was found with	-
		hat she ate for breakfast but		seat cushion. At the time	
	she could not tell the	time, day or month.	1	dycem was placed in the	e residents seat

Facility ID: 20050005

If continuation sheet Page 41 of 81

		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	· · ·	TE SURVEY MPLETED
		345534	B. WING		0	C 8/09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
SANFOR	D HEALTH & REHABILI	TATION CO		2702 FARRELL ROAD SANFORD, NC 27330		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG		ON SHOULD BE HE APPROPRIATE	COMPLETIO
F 689	Continued From page	ge 41	F 6	89		
	On 8/8/18 at 10:58	-				
		as assigned to Resident #57		Individual fall intervention lo	gs will be	
	on 4/11/18. She sta	ted that Resident #57 was		updated by the Director of N	lursing,	
		dent was on partial weight		Assistant Director of Nursing		
	-	due to right femur fracture		Managers x 2, and/or week		
		n immobilizer to her right lower 3 had answered the call light		daily to ensure documentati interventions are in use, and		
		ent in the bathroom. She		assessments are completed		
c ti n r		t, sat her on the toilet and left		fall. Individual intervention I		
		sposable brief. When the		maintained in a notebook ar	•	
	-	of the bathroom to the		nursing staff at all times.		
	resident's room, the	resident stood up and fell.				
				Licensed nursing staff will c		
		M, Nurse #3, the previous		risk assessment on each re-		
	-	(DON) was interviewed. She wered the bathroom call light		admission/re-admission, qua after any fall. The fall risk as	-	
		nd Resident #57 in the		be utilized to identify circum		
		let. She stepped out of the		leading to a fall, identify risk		
		ident's room to get a		falls, and implement interve		
		en the resident stood up and		prevent falls.		
	fell. Nurse #3 revea	aled that she didn't know the				
		atus nor her weight bearing				
	status at that time.			All new admissions, re-adm	·	
	On 8/0/18 at 0.10 A	M. Clinical Managor #1 was		residents experiencing a fal		
		M, Clinical Manager #1 was ated that she had investigated		discussed among the interd team during the weekly pati		
		1/11/18. Resident #57 was left		meeting for a minimum of 4		
		attended by Nurse #3 after		ensure that interventions are		
	providing care. The	e resident was on partial		to make any recommendation		
		us and should have not left in		changes in or additional inte		
		rself. The Clinical Manager		patients-at-risk meeting will		
		at the resident went to the		week. Documentation of this	•	
	bathroom by hersel	I.		be recorded in the individua progress notes in the electro		
	On 8/9/18 at 9.52 A	M, Nurse #1 was again		record at the time of the me		
		ated that she didn't know who		interdisciplinary team. Resid		
		t to the bathroom but she had		plans and care guides will b		
	-	to the bathroom by herself.		needed by the interdisciplina	•	
		that Resident #57 could not				

Facility ID: 20050005

If continuation sheet Page 42 of 81

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 09/04/2018 RM APPROVED O. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		345534	B. WING		08	C B/ 09/2018
NAME OF PF	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COI		
SANFORD	HEALTH & REHABILITA	ATION CO		2702 FARRELL ROAD		
04015				SANFORD, NC 27330 PROVIDER'S PLAN OF CO		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	steady and was wear should have not left a On 8/9/18 at 4:07 PM Director of Nursing w Administrator stated t know the resident's st	an herself. She was not ing an immobilizer. She lone in the bathroom. I, the Administrator and the	F 68	 89 The Director of Nursing initia in-service to all department h 8/24/18 regarding ensuring fa interventions are in place wh room rounds Monday throug in-service included a list of al interventions for each reside The Assistant Director of Nur an in-serviced to all licensed on 8/24/18 regarding comple falls risk assessment. This in included contacting the Director the time of a fall and implement interventions for residents de be at high risk for fall. All new licensed nursing staff will rect appropriate education during No staff will work until they h the appropriate education. The Assistant Director of Nur an in-serviced to all nursing s 8/24/18 regarding utilizing the intervention spreadsheet, rest guide, and care plan. This in- included the importance of nur resident unattended while in without knowing the resident 	neads on all len making h Friday. This II nt. rsing initiated nursing staff etion of the n-service ctor of of Nursing at enting fall etermined to wly hired petermined to wly hired petermined to wly hired petermined to wly hired service or of all staff on e fall sident care -service ot leaving a the bathroom	
				cognitive status. All newly hir staff will receive the appropri during orientation. No staff w they have received the appro- education. To ensure quality assurance, Room Round Records, admi staff will audit 100% of reside	iate education vill work until opriate , utilizing nistrative	

Event ID: S6KG11

Facility ID: 20050005

If continuation sheet Page 43 of 81

					OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345534	B. WING		C 08/09/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SANFORD	HEALTH & REHABILITA	TION CO		2702 FARRELL ROAD	
				SANFORD, NC 27330	1
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETIC
F 689	Continued From page	243	F 689		
	Continued From page		F 009	times weekly x 4 weeks and then weekly x 2 months to ensure fall interventions are in place. The Dir Nursing or Assistant Director of N will be notified immediately of any residents observed without planne interventions in place. The Admin will review the audit tools weekly i weeks, then monthly x 2 month for and concerns.	rector of ursing / ed istrator x 4
				To ensure quality assurance, utiliz Fall PAR (Patients-At-Risk) Audit Director of Nursing will audit PAR weekly x 8 weeks then monthly x ensure any resident experiencing within the previous 4 weeks is bei discussed weekly with the interdis team to ensure that interventions effective and to make any recommendations for changes in additional interventions.	tool, the minutes 1 to a fall ing sciplinary are
				The Director of Nursing will prese results of these audits to the Qual Assurance Performance Improve Committee for a minimum of three consecutive meetings to identify t concerns, and recommendations modification of the process.	lity ment e rends,
F 756	Drug Regimen Povici	ν, Report Irregular, Act On	F 756	The Director of Nursing will be responsible for implementing the correction.	plan of 9/5/18
	CFR(s): 483.45(c)(1)(· •			0110
	§483.45(c) Drug Reg	mon Roview			

Event ID: S6KG11

Facility ID: 20050005

If continuation sheet Page 44 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/04/2018 / APPROVED). 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345534	B. WING				C 09/2018
NAME OF PF	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SANEODD	HEALTH & REHABILITA			27	02 FARRELL ROAD		
JANFORD				S	ANFORD, NC 27330		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	CTION SHOULD BE COMPLET O THE APPROPRIATE DATE	
F 756	must be reviewed at I licensed pharmacist. §483.45(c)(2) This re- of the resident's media §483.45(c)(4) The ph- irregularities to the at- facility's medical direct and these reports mu- (i) Irregularities included drug that meets the c- (d) of this section for a (ii) Any irregularities r- during this review mu- separate, written repo- attending physician a director and director c- minimum, the residen and the irregularity th (iii) The attending phy- resident's medical rec- irregularity has been taken be no change in the r- physician should doct the resident's medical §483.45(c)(5) The fac- maintain policies and drug regimen review fi limited to, time frames the process and steps when he or she identi-	ug regimen of each resident least once a month by a view must include a review ical chart. armacist must report any tending physician and the ctor and director of nursing, ist be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist ist be documented on a bort that is sent to the nd the facility's medical of nursing and lists, at a at's name, the relevant drug, e pharmacist identified. vsician must document in the cord that the identified reviewed and what, if any, n to address it. If there is to medication, the attending ument his or her rationale in	F	756			
	by: Based on record revi	iew, observation, staff			The Pharmacy Consultant failed to		

Facility ID: 20050005

If continuation sheet Page 45 of 81

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO.	0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE S COMPL	
		345534	B. WING			; 9/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		19/2010
				2702 FARRELL ROAD		
SANFOR) HEALTH & REHABILITA	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 C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 756	Continued From page	245	F 75	56		
	interview, and Pharm the Pharmacy Consu address/readdress th prescribed on an inde adequate clinical indiu #44, and #45) and fai an Abnormal Involunt assessment (an asse involuntary movement antipsychotic medical antipsychotic medical residents reviewed. The findings included 1. Resident #4 was a 2/21/17 with diagnose left and right lower ey sags outward, away f surface of your inner A physician ' s order f 10/19/17 indicated Er percent (%) eye ointh ribbon onto lower cor to ectropion. There w order. The quarterly Minimu assessment dated 11 s cognition was seven	acy Consultant interview, Itant failed to identify and e use of an antibiotic efinite basis and without an cation for use (Residents #4, iled to complete a review for ary Movement Scale ssment utilized to monitor its for persons on tion) upon initiation of a new tion (Resident #18) for 4 of 5 : : : : : : : : : : : : : : : : : : :		 identify and address/read an antibiotic prescribed of basis and without an ade indication for use and fail review or recommend an assessment upon initiation antipsychotic medication. The antibiotic prescribed was discontinued on 8/10. The Responsible Represe Resident #45 was contact the Director of Nursing re currently prescribed antib Responsible Representate educated on the risks ver antibiotic use in the abse infection. The Responsible Representative verbalized understanding of education requests that the antibiotid discontinued citing that e medication has been disco past, her mother has exp related to urinary tract inf #45 is currently on hospic Responsible Representate wishes to keep her mother and pain free. The Medic Hospice were consulted of regarding the use of prop- antibiotics and agreed that 	n an indefinite quate clinical ed to complete a AIMS on of a new for Resident #4 0/18. entative for ted on 8/7/18 by egarding the biotic. The tive was rsus benefits of nce of an active le d an on; however, ic not be ach time this continued in the erienced pain fections. Resident ce services and tive states she er comfortable al Director and on 8/7/18 whylactic	
	Resident #4 was asso infections. A Pharmacy Consulta	left and right lower eyelids. essed with no active ant recommendation dated thromycin eye ointment was		outweigh the risks of use case as resident is on ho and has not had any side adverse reactions to the resident has not experien tract infection since initiat	spice services effects or antibiotic. The nced a urinary	

Event ID: S6KG11

Facility ID: 20050005

If continuation sheet Page 46 of 81

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G	· · · ·	IPLETED
						С
		345534	B. WING		0	8/09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SANEODE	HEALTH & REHABILIT			2702 FARRELL ROAD		
SANFURL				SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULL EGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY) DEFICIENCY)		HOULD BE	(X5) COMPLETIO DATE	
F 756	Continued From page	e 46	E 7	56		
		d no stop date was issued.		prophylactic antibiotic. Resident	s care	
		was to check with the		plan updated on 8/7/18 by the N		
		was able to be discontinued		Coordinator.		
	as it was usually orde	ered with a 10 to 14-day				
		mendation was reviewed		The antibiotic prescribed for Res	sident #44	
		ysician ' s Assistant (PA) on		was discontinued on 8/7/18.		
		d to refer to the optometry				
	follow up appointmer	1t.		An Abnormal Involuntary Moven (AIMS) assessment was completed		
	The quarterly MDS a	ssessment dated 5/1/18		Resident #18 on 8/8/18 by the L		
	indicated Resident #4	4 's cognition was severely idministered antibiotics on 7		Manager.	5 111	
		MDS review period. Her		A 100% audit of all active physic	cian orders	
	active diagnoses incl	uded ectropion of left and		was completed on 8/21/18 by th	e	
		Resident #4 was assessed		Pharmacy Consultant to identify		
	with no active infection	ons.		currently prescribed antibiotics i		
	A marian of Desident			absence of an active infection. (
		#4 ' s current physician ' s d on 8/7/18. The orders		resident was noted to have an a order for antibiotic eye drops wit		
		nycin eye ointment order that		stop date. Recommendations w		
		9/17. A further review of		to the prescribing provider on 8/		
		d revealed there continued to		the discontinuation of this medic		
	be no stop date for th			the medication was discontinue		
	ointment.			8/22/18 per provider orders.		
	A review of the month	hly drug regimen reviews and		100% of residents received an A	AIMS	
		idations for Resident #4		assessment completed by the L	Jnit	
		nention of the Erythromycin		Manager on 8/17/18 with two re		
	eye ointment after the to discontinue the me	e 1/16/18 recommendation edication.		identified as having tardive dysk		
	An interview was con	nducted with the Director of		The Pharmacy Consultant was by Managing Pharmacist on 8/2		
		7/18 at 3:40 PM. She		regarding drug regimen review a		
	- · ·	sponsible for monitoring		antibiotic stewardship policies a		
		e facility. The DON was		procedures. This in-service inclu		
		prescribed for prophylaxis		requirement for the Pharmacy C		
		adequate clinical indication		to identify and address/readdres		
		ed she was not sure, but that		antibiotic prescribed on an indef		
	she was aware the fa	acility tried to deter from the		and/or without clinical indication	for use.	

Facility ID: 20050005

If continuation sheet Page 47 of 81

			0.00			O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		. ,	E SURVEY PLETED
			A. BUILDING	<u> </u>		
		345534	B. WING			C
	ROVIDER OR SUPPLIER	545554		STREET ADDRESS, CITY, STATE, 2		/09/2018
	ROVIDER OR SUFFLIER			2702 FARRELL ROAD		
SANFOR	DHEALTH & REHABILIT	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	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 756	Continued From page	e 47	F 75	56		
	use of prophylactic a	ntibiotics. She explained		This in-service included	following the	
		en over responsibility of		pharmacy's policy on A		
		itoring about a month and a		and making recommen		
		stated she needed to follow		assessments with each	antipsychotic	
		responsible staff member to		dosage change.		
	provide additional info	ormation.		The Dharmony Canault	ant will identify and	
	An interview was con	ducted with the Admissions		The Pharmacy Consult address/readdress any		
		8 at 3:50 PM. She stated		prescribed on an indefi		
s		for monitoring antibiotic		without clinical indication		
	-	a month and a half ago.		necessary recommenda		
		iotics were expected to have		prescribing physician. T		
	an adequate clinical i	indication for use and were		Consultant will make re	commendations	
	also expected to have	e a specified duration. She		for AIMS assessments	for any resident	
	revealed that an antil			with an antipsychotic do		
		not an adequate clinical		Pharmacy Consultant w		
	indication for use.			conference with the Ad		
	A phone interview we	a conducted with the		Director of Nursing mor		
		as conducted with the to 8/9/18 at 1:05 PM. The		complete list of all resid		
		t was asked if she identified		assessments for review		
	-	ylactic antibiotics that were				
		y during her monthly drug		All antibiotic orders will	be verified by the	
		e Pharmacy Consultant		Unit Managers x 2, Ass	•	
	stated she normally w	vaited 4 to 6 months after		Nursing, and Director o	f Nursing 5 x	
	admission and/or init	iation of the antibiotic and		weekly to ensure diagn	osis and stop	
	would then make a re			dates.		
		fections had occurred. The				
	· ·	idation dated 1/16/18 to		AIMS assessments will		
		romycin eye ointment for		the MDS Coordinator u		
		ewed with the Pharmacy ed that this was an instance		new antipsychotic, at ea dosage change, and qu		
		d Resident #4 was on a		residents currently pres	•	
		c and had no infections, so		antipsychotic.		
	-	s discontinuation. She		2		
	revealed she had ma			In order to provide Qua	lity Assurance,	
		ated to Resident #4 's		utilizing an Antibiotic QI	-	
	Erythromycin eye oin	tment after 1/16/18. She		Assistant Director of Nu		
	explained that after h	er recommendation to		active antibiotic orders	weekly x 4 weeks	

Facility ID: 20050005

If continuation sheet Page 48 of 81

					FORI	D: 09/04/2018 MAPPROVED D. 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMF	E SURVEY PLETED
	345534	B. WING				C / 09/2018
ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
			27	02 FARRELL ROAD		
			S	ANFORD, NC 27330		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
discontinue the media decision up to the phy An interview was con Administrator on 8/9/ she expected the Pha and address the use with no stop date and indication for use dur regimen reviews. Sh pharmacy recommen prophylactic antibiotic physician that she ex Consultant to continu usage and to readdre recommendations. 2. Resident #45 was 3/14/18 with diagnose kidney disease stage palliative care. A physician ' s order of Keflex (antibiotic) 250	cation on 1/16/18 she left the ysician. ducted with the 18 at 4:10 PM. She stated armacy Consultant to identify of an antibiotic prescribed without an adequate clinical ing the monthly drug he reported that if an initial dation to discontinue a c was declined by the pected the Pharmacy e to monitor the antibiotic ' s ess it in further admitted to the facility on es that included chronic 3, heart failure, and dated 3/14/18 indicated 0 milligrams (mg) once daily	F	756	antibiotic prescribed has a clinical indication and a stop date. The Assist Director of Nursing will notify the prescribing provider of any concerns a identification. In order to provide Quality Assurance utilizing an AIMS Audit Tool the Direct Nursing will audit all residents current prescribed an antipsychotic weekly x weeks then monthly x 2 months to en that AIMS assessments have been completed quarterly, upon initiation of new antipsychotic, and at each antipsychotic dosage change.	ant upon or of ly 4 sure	
A Physician 's Assist indicated Resident #4 Keflex related to a his Infections (UTIs). Th for discontinuation if I Responsible Party (R A nursing note dated #45 was on a prophy UTIs.	ant (PA) note dated 3/15/18 45 was on prophylactic story of Urinary Tract e PA noted that she advised Resident #45 ' s P) agreed. 3/15/18 indicated Resident lactic antibiotic related to					
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER D HEALTH & REHABILIT/ SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page discontinue the medic decision up to the phy An interview was con Administrator on 8/9/ she expected the Pha and address the use with no stop date and indication for use dur regimen reviews. SF pharmacy recommen prophylactic antibiotic physician that she ex Consultant to continu usage and to readdre recommendations. 2. Resident #45 was 3/14/18 with diagnose kidney disease stage palliative care. A physician 's order of Keflex (antibiotic) 250 for prophylaxis (prevent A Physician 's Assisted indicated Resident #44 Keflex related to a his Infections (UTIs). Th for discontinuation if I Responsible Party (R A nursing note dated #45 was on a prophy UTIS.	CORRECTION IDENTIFICATION NUMBER: 345534 ROVIDER OF DEFICIENCIES DHEALTH & REHABILITATION CO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 48 discontinue the medication on 1/16/18 she left the decision up to the physician. An interview was conducted with the Administrator on 8/9/18 at 4:10 PM. She stated she expected the Pharmacy Consultant to identify and address the use of an antibiotic prescribed with no stop date and without an adequate clinical indication for use during the monthly drug regimen reviews. She reported that if an initial pharmacy recommendation to discontinue a prophylactic antibiotic was declined by the physician that she expected the Pharmacy Consultant to continue to monitor the antibiotic ' s usage and to readdress it in further recommendations. 2. Resident #45 was admitted to the facility on 3/14/18 with diagnoses that included chronic kidney disease stage 3, heart failure, and palliative care. A physician ' s order dated 3/14/18 indicated Keflex (antibiotic) 250 milligrams (mg) once daily for prophylaxis (prevention). A Physician ' s Assistant (PA) note dated 3/15/18 indicated Resident #45 was on prophylactic Keflex related to a history of Urinary Tract Infections (UTIs). The PA noted that she advised for discontinuation if Resident #45 ' s Responsible Party (RP) agreed. A nursing note dated 3/15/18 indicated Resident #45 was on a prophylactic antibiotic related to	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 345534 B. WING ROVIDER OR SUPPLIER 345534 B. WING CONTINUE OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IP IP Continued From page 48 discontinue the medication on 1/16/18 she left the decision up to the physician. F IP An interview was conducted with the Administrator on 8/9/18 at 4:10 PM. She stated she expected the Pharmacy Consultant to identify and address the use of an antibiotic prescribed with no stop date and without an adequate clinical indication for use during the monthly drug regimen reviews. She reported that if an initial pharmacy recommendation to discontinue a prophylactic antibiotic was declined by the physician that she expected the Pharmacy Consultant to continue to monitor the antibiotic ' s usage and to readdress it in further recommendations. 2. Resident #45 was admitted to the facility on 3/14/18 with diagnoses that included chronic kidney disease stage 3, heart failure, and palliative care. A physician 's order dated 3/14/18 indicated Keflex (antibiotic) 250 milligrams (mg) once daily for prophylaxis (prevention). A Physician 's Assistant (PA) note dated 3/15/18 indicated Resident #45 was on prophylactic Keflex related to a history of Urinary Tract Infections (UTIs). The PA noted that she advised for discontinuation if Resident #45 's Responsible Party (RP) agreed. A nursing note dated 3/15/18 indicated Resident #45 was on a prophylactic antibiotic relate	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (1) PROVIDER/UPPLICE/CLAID OP DEFICIENCIES (2) MULTIPLE CONSTRUCTION A BUILDING A BUILDING A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE CORNECTION STREET ADDRESS, CITY, STATE, ZIP CODE Consultation STREET ADDRESS, CITY, STATE, ZIP CODE Continued Form page 48 PROVIDER/SPLAN OF CORRECTION An interview was conducted with the Antimistrator on 8/9/18 at 4:10 PM. She stated An interview was conducted with the Antimistrator on 8/9/18 at 4:10 PM. She stated An interview was conducted with the Antimistrator on 8/9/18 at 4:10 PM. She stated State and thibolic prescribed In order to provide Claulity Assurance with no stop date and without an adequate clinical In order to provide Claulity Assurance Indication on subjoit and she expected the Pharmacy cooming the antibiotic 's In order to provide Claulity Assurance Indication in a she expected the refacility on 3/14/18 with diagnoses that included chronic kidney disease stage 3, heart failure, and palilative care. A physician 's assistant (PA) note dated 3/15/18 indicated Resident #45 was on prophylactic Kefex related to a history of Urinary Tract Infercion (IPA), The PAPROPE Prespisable Party (RP) agreed. </td <td>MENT OF HEALTH AND HUMAN SERVICES FOR SE OR MEDICARE & MEDICAD SERVICES ONB NO PERCENCIES ONB NO PERCENCIES ONB NO PROVIDER OR SUPPLIER 346534 PHEALTH & REHABILITATION CO STREETADREES. CITY, STATE, ZP CODE 2722 FARRELL ROAD 2722 FARRELL ROAD SUMMARY STATEMENT OF DEFICIENCIES IN (RCAL DEFICIENCY MUST RE PRECODED BY FULL PROVIDERS PLAY OF CORRECTION REGULATORY OR LSC DENTFYNNS INFORMATION; IN Continued From page 48 F 756 discontinue the medication on 1/16/18 she left the In order of Nursing will notify the decision up to the physician. Provide Caulting Assistant An interview was conducted with the In order to provide of any concerns upon identification. An interview was conducted with the Administrator on 86/18 at 4:10 PM. She stated she expected the Pharmacy Consultant to idecontinue a proshydactic antibiotic prescribed In order to provide Quality Assurance, utilizing an AIMS Audit Tool the Director of Nursing will audit all residents currently prescribed an antibycholic, weekly x 4 weeks then monthy 4:2 months to ensure each antibiotic susge and to readdress it in further and pallative care. The Administrator will be responsible for the plan of correction. 2. Resi</td>	MENT OF HEALTH AND HUMAN SERVICES FOR SE OR MEDICARE & MEDICAD SERVICES ONB NO PERCENCIES ONB NO PERCENCIES ONB NO PROVIDER OR SUPPLIER 346534 PHEALTH & REHABILITATION CO STREETADREES. CITY, STATE, ZP CODE 2722 FARRELL ROAD 2722 FARRELL ROAD SUMMARY STATEMENT OF DEFICIENCIES IN (RCAL DEFICIENCY MUST RE PRECODED BY FULL PROVIDERS PLAY OF CORRECTION REGULATORY OR LSC DENTFYNNS INFORMATION; IN Continued From page 48 F 756 discontinue the medication on 1/16/18 she left the In order of Nursing will notify the decision up to the physician. Provide Caulting Assistant An interview was conducted with the In order to provide of any concerns upon identification. An interview was conducted with the Administrator on 86/18 at 4:10 PM. She stated she expected the Pharmacy Consultant to idecontinue a proshydactic antibiotic prescribed In order to provide Quality Assurance, utilizing an AIMS Audit Tool the Director of Nursing will audit all residents currently prescribed an antibycholic, weekly x 4 weeks then monthy 4:2 months to ensure each antibiotic susge and to readdress it in further and pallative care. The Administrator will be responsible for the plan of correction. 2. Resi

If continuation sheet Page 49 of 81

S FOR MEDICARE & I	MEDICAID SERVICES			OMB N	0.0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY PLETED
	345534	B. WING		08	C 8/09/2018
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	0072010
HEALTH & REHABILITA	ATION CO				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETIO DATE
Resident #45 was on to a history of UTIs. The quarterly Minimul assessment dated 6/7 #45 ' s cognition was administered antibioti MDS review period. If with no active infection A review of Resident if orders was conducted included the Keflex 29 prophylaxis that was if review of Resident #4 continued to be no stor Keflex. There was no evidence medical record of the identifying and address Trimethoprim prescrite An interview was com- Manager #2 on 8/7/18 Resident #45 had bee since her admission of Keflex was prescribed An interview was com- Nursing (DON) on 8/7 indicated she was ress antibiotic usage at the asked if an antibiotic pro- state in the store of the store antibiotic pro- aster in the store of the store antibiotic usage at the store of the store asked if an antibiotic pro- state of the store of the store of the store of the store antibiotic pro- state of the store of t	prophylactic Keflex related m Data Set (MDS) 19/18 indicated Resident severely impaired. She was cs on 7 of 7 days during the Resident #45 was assessed ns. #45 ' s current physician ' s d on 8/7/18. The orders 50 mg once daily for initiated on 3/14/18. A further 55 ' s record revealed there op date for the prophylactic bed in Resident #44 ' s Pharmacy Consultant ssing the use of prophylactic bed indefinitely. ducted with Clinical 8 at 1:08 PM. She reported en on prophylactic Keflex on 3/14/18. She stated active infection and that the d with no stop date. ducted with the Director of 7/18 at 3:40 PM. She sponsible for monitoring e facility. The DON was prescribed for prophylaxis	F 756			
	PEDEFICIENCIES CORRECTION ROVIDER OR SUPPLIER HEALTH & REHABILITA SUMMARY ST, (EACH DEFICIENC' REGULATORY OR I Resident #45 was on to a history of UTIs. The quarterly Minimu assessment dated 6/7 #45 ' s cognition was administered antibioti MDS review period. I with no active infection A review of Resident orders was conducted included the Keflex 22 prophylaxis that was review of Resident #4 continued to be no sto Keflex. There was no evidend medical record of the identifying and addres Trimethoprim prescrite An interview was con Manager #2 on 8/7/18 Resident #45 had be since her admission of Resident #45 had no Keflex was prescribed	OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345534 ROVIDER OR SUPPLIER HEALTH & REHABILITATION CO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 Resident #45 was on prophylactic Keflex related to a history of UTIs. The quarterly Minimum Data Set (MDS) assessment dated 6/19/18 indicated Resident #45 's cognition was severely impaired. She was administered antibiotics on 7 of 7 days during the MDS review period. Resident #45 was assessed with no active infections. A review of Resident #45 's current physician 's orders was conducted on 8/7/18. The orders included the Keflex 250 mg once daily for prophylaxis that was initiated on 3/14/18. A further review of Resident #45 's record revealed there continued to be no stop date for the prophylactic	pF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A BUILDING ad5534 B. WING ROVIDER OR SUPPLIER IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: HEALTH & REHABILITATION CO ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 49 F 756 Resident #45 was on prophylactic Keflex related to a history of UTIs. F The quarterly Minimum Data Set (MDS) assessment dated 6/19/18 indicated Resident #45 's cognition was severely impaired. She was administered antibiotics on 7 of 7 days during the MDS review period. Resident #45 was assessed with no active infections. F A review of Resident #45 's current physician 's orders was conducted on 8/7/18. The orders included the Keflex 250 mg once daily for prophylaxis that was initiated on 3/14/18. A further review of Resident #45 's record revealed there continued to be no stop date for the prophylactic Keflex. There was no evidence in Resident #44 's medical record of the Pharmacy Consultant identifying and addressing the use of prophylactic Trimethoprim prescribed indefinitely. An interview was conducted with Clinical Manager #2 on 8/7/18 at 1:08 PM. She reported Resident #45 had no active infection and that the Keflex was prescribed with no stop date. An interview was conducted with the Director of Nursing (DON) on 8/7/18 at 3:40 PM. She indicated she was responsible for monitoring antibiotic usage at the f	procession [X1] PROVIDERSUPPLERCIAL IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE INTERCIATION CO STREET ADDRESS, CITY, STATE, ZIP CODE INTERCIATION CO STREET ADDRESS, CITY, STATE, ZIP CODE INTERCIATION CO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENTY WIDE INFORMATION) ID PROVIDERS PLAN OF COR (EACH CORRECTIVE AND OF COR (EACH CORRECTIVE ACTIONS) Continued From page 49 Resident #45 was on prophylactic Keflex related to a history of UTIs. The quarterly Minimum Data Set (MDS) assessment dated 6/19/18 indicated Resident #45 's cognition was severely impaired. She was administered antibiotics on 7 of 7 days during the MDS review period. Resident #45 was assessed with no active infections. A review of Resident #45 's current physician 's included the Keflex 250 mg once daily for prophylaxis that was initiated on 31/1/18. A further review of Resident #45 's cercor drevealed there continued to be no stop date for the prophylactic Keflex. There was conducted on the Resident fat44 's medical record of the Pharmacy Consultant identifying and addressing the use of prophylactic Trimethoprim prescribed indefinitely. An interview was conducted with Clinical Manager #2 on 87/18 at 13:40 PM. She reported Resident #45 had no active infection and that the Keflex was prescribed with no stop date. An interview was conducted with the Director of Nursing (DON) on 87/18 at 3:	OPENCIENCIES CORRECTION (X1) PROVIDERSUPPLIERCLA DENTIFICATION NUMBER: (X2) MALTIPLE CONSTRUCTION A BUILDING ABUILDING (X3) OM A BUILDING INCLUDER HEALTH & REHABILITATION CO STREET ADDRESS, CITY, STRE, ZIP CODE Z702 FARRELL ROAD SANFORD, NC 27330 (X3) PROVIDER PREVENT OF DEFICIENCES PREVENT OF DEFICIENCES PREVENT OF DEFICIENCES PREVENT OF DEFICIENCES PREVENT OF LSC IDENTIFYING INFORMATION) ID PREVENT FACH DEFICIENCY NUST BE PREVENT OF DEFICIENCES PREVENT OF LSC IDENTIFYING INFORMATION) ID PREVENT FACH DEFICIENCY ID PREVENT FACH DEFICIENCY Continued From page 49 Resident #45 was on prophylactic Keflex related to a history of UTIs. F 756 The quarterly Minimum Data Set (MDS) assessment dated 6/19/18 indicated Resident #45 's cognition was severely impaired. She was administered antibiotics on 7 of 7 days during the MDS review period. Resident #45 vas assessed with no active infections. F 756 A review of Resident #45 's current physician 's orders was conducted on 8/7/18. The orders included the Keflex 250 mg once daily for prophylaxis that was initiated on 3/14/18. A further review of Resident #45 's crossultant identifying and addressing the use of prophylactic Keflex. No review and Addressing the use of prophylactic Keflex. An interview was conducted with Clinical Manager #2 on 8/7/18 at 1:08 PM. She reported Resident #45 had heen an ophylactic Keflex since her admission on 3/14/18. She stated Resident #45 had heen active infection and that the Keflex was prescribed with no stop date. An interview was anadequate clinical indication An interview was conducted with the Director of Nursing (DON) on 8/7/18 at

Facility ID: 20050005

If continuation sheet Page 50 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345534	B. WING				C 09/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SANFORD	HEALTH & REHABILITA	ATION CO			702 FARRELL ROAD ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 756	antibiotic usage monifilial ago. The DON si up with the previous riprovide additional info An interview was come Coordinator on 8/7/18 she was responsible fusage up until about a She stated that antibilian adequate clinical in also expected to have revealed that an antibility and adequate clinical in also expected to have revealed that an antibility prophylactically was ri- indication for use. A phone interview wa Pharmacy Consultant Pharmacy Consultant and addressed proph prescribed indefinitely regimen reviews. The stated she normally wa admission and/or initii would then make a re- discontinue it if no info order for Resident #4 had been in place sin with the Pharmacy Co- she had made no reco Resident #45 ' s prop An interview was come Administrator on 8/9/7 she expected the Pha- and address the use of	n over responsibility of toring about a month and a tated she needed to follow esponsible staff member to ormation. ducted with the Admissions a tate of the Admissions at 3:50 PM. She stated for monitoring antibiotic a month and a half ago. otics were expected to have ndication for use and were a specified duration. She notic ordered not an adequate clinical s conducted with the ton 8/9/18 at 1:05 PM. The twas asked if she identified ylactic antibiotics that were of during her monthly drug e Pharmacy Consultant vaited 4 to 6 months after ation of the antibiotic and commendation to ections had occurred. The 5 's prophylactic Keflex that ce 3/14/18 was reviewed onsultant. She confirmed ommendations related to hylactic Keflex. ducted with the 18 at 4:10 PM. She stated armacy Consultant to identify of an antibiotic prescribed without an adequate clinical	F	756			

Facility ID: 20050005

If continuation sheet Page 51 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345534	B. WING				C / 09/2018
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SANFOR) HEALTH & REHABILITA	ATION CO			2702 FARRELL ROAD SANFORD, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 756	Continued From page regimen reviews.	e 51	F	756	5		
		admitted to the facility on es that included Alzheimer ' s					
	3/21/18 completed pr facility indicated she I Urinary Tract Infection	ative) antibiotics. Resident					
	Trimethoprim (antibio	dated 3/21/18 indicated tic) 100 milligrams (mg) nt #44. There was no stop					
	-	ant (PA) note dated 3/22/18 I4 was on prophylactic story of UTIs.					
		ated 3/26/18 indicated Trimethoprim for recurrent					
	#44 ' s cognition was administered antibioti	26/18 indicated Resident severely impaired. She was cs on 7 of 7 days during the Resident #44 was assessed					
	orders was conducted included the Trimetho UTI prophylaxis that v	#44 ' s current physician ' s d on 8/7/18. The orders pprim 100 mg once daily for was initiated on 3/21/18. A dent #44 ' s record revealed					

If continuation sheet Page 52 of 81

N SERVICES				FORM): 09/04/2018 / APPROVED) 0938-0391
IDER/SUPPLIER/CLIA	. ,			(X3) DATE COMP	SURVEY LETED
345534	B. WING		_		C 09/2018
		STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA		(X5) COMPLETION DATE
Ident #44 ' s y Consultant use of prophylactic nitely. th Clinical AM. She reported phylactic ion on 3/21/18. to active infection prescribed with no th the Director of 0 PM. She for monitoring The DON was d for prophylaxis clinical indication s not sure, but that to deter from the She explained sponsibility of but a month and a needed to follow le staff member to th the Admissions PM. She stated oring antibiotic and a half ago. e expected to have for use and were led duration. She	F 756				
	D SERVICES D SERVICES D SERVICES DEF/SUPPLIER/CLIA IFICATION NUMBER: 345534 F DEFICIENCIES PRECEDED BY FULL PRECEDED BY FULL PREC	D SERVICES IDER/SUPPLIER/CLIA IFICATION NUMBER: 345534 B. WING	D SERVICES IDER/SUPPLER/CLIA IFICATION NUMBER: 345534 B. WING STREET ADDRESS, CITY, ST 2702 FARRELL ROAD SANFORD, NC 27330 F DEFICIENCIES PRECEDED BY FULL YING INFORMATION) PRECEDED BY FULL YING INFORMATION) F 756 date for the ident #44 's ty Consultant use of prophylactic nitely. ath Clinical 0 AM. She reported phylactic ion on 3/21/18. no active infection prescribed with no with the Director of 40 PM. She for monitoring The DON was d for prophylaxis clinical indication s not sure, but that I to deter from the She explained sponsibility of built a month and a needed to follow le staff member to with the Admissions PM. She stated pring antibiotic<	DSERVICES IDERSUPPLIENCLA IFICATION NUMBER: 345534 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 2730 F DEFICIENCIES PRECEDED BY FULL Streation STREET ADDRESS FULL STREET ADDRESS FULL STREET ADRESS FULL	D SERVICES ONB NC IDERRUPCES (X2) MULTPLE CONSTRUCTION (X3) DATE 345534 B. WING (08) 345534 B. WING (08) STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330 STREET ADDRESS, CITY, STATE, ZIP CODE PRECEDED bY FULL ID PREPRX YING INFORMATION) PREPIX IC PRECEDED bY FULL ID PREPIX YING INFORMATION) F 756 IE

Facility ID: 20050005

If continuation sheet Page 53 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/04/2018 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345534	B. WING		_) 08/) 09/2018
NAME OF PF	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SANFORD	HEALTH & REHABILITA			702 FARRELL ROAD SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page prophylactically was n indication for use.	e 53 not an adequate clinical	F 756				
	Pharmacy Consultant and addressed prophy prescribed indefinitely regimen reviews. The stated she normally w admission and/or initia would then make a re discontinue it if no infe order for Resident #44 Trimethoprim that had 3/21/18 was reviewed Consultant. She conf recommendations rela prophylactic Trimethop An interview was cond Administrator on 8/9/1	t on 8/9/18 at 1:05 PM. The t was asked if she identified ylactic antibiotics that were v during her monthly drug e Pharmacy Consultant vaited 4 to 6 months after ation of the antibiotic and commendation to ections had occurred. The 4 ' s prophylactic d been in place since d with the Pharmacy firmed she had made no ated to Resident #44 ' s prim.					
	and address the use of	of an antibiotic prescribed without an adequate clinical					
	5/22/17 with diagnose dementia with behavio An Abnormal Involunt assessment was com	ary Movement Scale (AIMS)					
	movements identified)						

Facility ID: 20050005

If continuation sheet Page 54 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/04/2018 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345534	B. WING _				C / 09/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SANFOR	HEALTH & REHABILIT	ATION CO			702 FARRELL ROAD		
				S	SANFORD, NC 27330		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 756	Continued From page	<u>-</u> 54	E 7	756			
	A review of a psychia 4/3/18 indicated the p Resident #18 's antip	try progress note dated ohysician was changing osychotic medication from tic medication) to Risperdal					
	Resident #18 ' s Serc	dated 4/3/18 indicated oquel was discontinued and ms (mg) at 1:00 PM and 1 ted.					
	continuation of Resid orders (0.5 mg at 1:0	dated 4/18/18 indicated a ent #18 ' s current Risperdal 0 PM and 1 mg at night) and dal 0.5 mg at 9:00 AM.					
	's cognition was seve the Medication Section	Data Set (MDS) 24/18 indicated Resident 18 erely impaired. Section N, on, indicated Resident #18 tipsychotic medications on 7					
	orders on 8/7/18 indic	#18 ' s current physician ' s cated Risperdal continued at .5 mg at 1:00 PM, and 1 mg					
	through 8/7/18 revea any other involuntary not been completed f new antipsychotic me	cal record from 4/3/18 led an AIMS assessment or movement assessment had for Resident #18 after the edication Risperdal was hen the Risperdal 's dosage 18).					
		ce in Resident #18 ' s Pharmacy Consultant ssing that an AIMS					

Facility ID: 20050005

If continuation sheet Page 55 of 81

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		10. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	MPLETED
						С
		345534	B. WING		0	8/09/2018
NAME OF PR	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD	E	
	HEALTH & REHABILIT			2702 FARRELL ROAD		
				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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 756	Continued From page	e 55	F 75	56		
		ther involuntary movement				
		been completed for Resident				
	#18 after the new ant	tipsychotic medication				
		ed (4/3/18) or when the				
	Risperdal 's dosage	was increased (4/18/18).				
	An observation was o	conducted of Resident #18				
	on 8/6/18 at 10:30 AM					
	movements noted.					
	A phone interview wa	as conducted with the				
		t on 8/9/18 at 1:05 PM. She				
	•	tation for the completion of				
		vas on initiation of a new				
		tion and annually thereafter hange in the dosage or a				
		nt's symptoms. She				
		spected a new AIMS to be				
	completed if any new	antipsychotic medication				
	was initiated. The Ph	-				
	-	important to complete a new				
		ychotic medication ' s ch medication had the				
		ferent side effects. Resident				
		IMS completed on 3/13/18				
		e Pharmacy Consultant.				
	Resident #18 's phys					
		n Risperdal on 4/3/18 as well				
	4/18/18 were reviewe	e Risperdal 's dosage on				
		fied she expected a new				
		d when the Risperdal had				
	been initiated and wh	nen it was increased. She				
		identified that an AIMS was				
		the Risperdal was initiated				
	on 4/3/18 or when it v	was increased on 4/18/18.				
	An interview was con	ducted with the				
			1			1

Facility ID: 20050005

If continuation sheet Page 56 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FOI	ED: 09/04/2018 RM APPROVEI NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345534	B. WING			0	C 8/09/2018
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SANFORD	HEALTH & REHABILIT	ATION CO		27	02 FARRELL ROAD		
				SA	ANFORD, NC 27330		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 756	Continued From page	56	Í -	756			
1750		armacy Consultant to review		/ 50			
		uring the monthly drug					
	regimen reviews and	to request a new AIMS					
		esident who was initiated on					
		nedication or had a change antipsychotic medication.					
F 758	-	chotropic Meds/PRN Use	F	758			9/5/18
SS=D	CFR(s): 483.45(c)(3)	•					
	affects brain activities processes and behave	pic Drugs. hotropic drug is any drug that associated with mental vior. These drugs include, drugs in the following					
		ensive assessment of a nust ensure that					
	psychotropic drugs an unless the medication	ents who have not used re not given these drugs n is necessary to treat a diagnosed and documented					
	drugs receive gradua behavioral interventic	ents who use psychotropic I dose reductions, and ons, unless clinically n effort to discontinue these					
		ents do not receive ursuant to a PRN order n is necessary to treat a					

Facility ID: 20050005

If continuation sheet Page 57 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 09/04/2018 FORM APPROVED B NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		STRUCTION	(X3)	DATE SURVEY COMPLETED
		345534	B. WING _				C 08/09/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREE	TADDRESS, CITY, STATE, ZIP CODE		
SANFOR	HEALTH & REHABILIT			2702 F	ARRELL ROAD		
				SANF	ORD, NC 27330		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			:	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 758	in the clinical record; §483.45(e)(4) PRN o are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the PF beyond 14 days, he of rationale in the reside indicate the duration of §483.45(e)(5) PRN of drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of This REQUIREMENT by: Based on record rev Assistant (PA) and st failed to have adequated duplicate therapy for residents reviewed for (Resident #90). Findings included: Resident #90 was ori on 1/6/16 and was re- multiple diagnoses in behaviors. The signif Data Set (MDS) asse indicated that Reside	and rders for psychotropic drugs s. Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order. rders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. T is not met as evidenced iew, Physician, Physician aff interview, the facility ate indication for the use of insomnia for 1 of 6 sampled or unnecessary medications ginally admitted to the facility admitted on 4/30/18 with cluding dementia with ficant change in Minimum essment dated 7/20/18 nt #90 had severe cognitive	F 7	TH inc for Nu ph of Re an Me or be to	he facility failed to have adequat dication for the use of duplicate to insomnia on Resident #90. urse #1 failed to notify the prescr ysician of Resident #90's current edications when she contacted to ysician regarding insomnia. At the the phone call to the physician, esident #90 was currently prescr d being administered Trazadone elatonin for insomnia. The physic dered for Restoril to be administed different for insomnia. Nurse #1 als document that the resident was	herapy ibing at he he time ibed e and cian ered at so failed	
	On 4/30/18, he had o	no behaviors. r's orders were reviewed. orders for Trazodone (an milligrams (mgs) - ½ tablet		tha ine	ffering from increased insomnia at the current medication regime effective. urrent physician orders for Resid	n was	

Facility ID: 20050005

If continuation sheet Page 58 of 81

	F DEFICIENCIES	MEDICAID SERVICES	(¥2) MI II TIB	LE CONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	3	. ,	PLETED
						С
		345534	B. WING	·····	08	/09/2018
NAME OF PF	ROVIDER OR SUPPLIER		- <u>'</u>	STREET ADDRESS, CITY, STATE, Z		
				2702 FARRELL ROAD		
SANFURD	HEALTH & REHABILITA	ATION CO		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETIO DATE
F 758	Continued From page	e 58	F 75	8		
		for insomnia and Melatonin		were reviewed by the pl	hvsician assistant	
	(used as a sleep aide bedtime for insomnia) 3 mgs by mouth at		and Restoril was discor	-	
				A 100% audit of all activ	/e physician orders	
		blan dated 7/19/18 was		for psychotrophics was		
		care plan problems was		8/21/18 by the Consulta		
		hotropic medications related		identify residents' curren		
	to diagnoses of depre	ession, dementia and vas for the resident to have		duplicate therapy. Five identified as being pres		
		ns of adverse reaction from		anti-depressant therapy		
		igh the next review date.		Consultant made recom	•	
		ided psychiatry to evaluate		prescribing provider for	any residents	
		/indicated, pharmacy and		identified to have duplic	ate therapy.	
		continued need for drug and				
		ed need for the medication		An in-service was initiat	-	
	per facility protocol.			Assistant Director of Nu 21, 2018 for all licensed		
	The June July and A	ugust 2018 Medication		regarding review of curr		
		ds (MARs) were reviewed		orders with the physicia		
		sident #90 had received the		new orders and comple		
	Trazodone and the M	elatonin every night as		including the reason for		
	ordered.			physician to obtain an o	-	
				hired licensed nursing s		
	reviewed. The notes	2018 nurse's notes were		appropriate education d Staff will not be allowed		
	Resident #90 was no			have received the in-se	•	
		ritten by Nurse #1) dated		During clinical meeting,		
	•	evealed that Resident #90 ed a skin tear to his left		Friday, all carbon copie received on the previou		
		a small abrasion to his left		reviewed with the Direc	-	
		cian was informed and he		Assistant Director of Nu	-	
		Restoril (a benzodiazepine)		Coordinator, and Unit N	-	
	7.5 mgs by mouth at	bedtime for insomnia and		During this review, any	orders for	
		th every 8 hours as needed		psychotropic drugs will		
	(PRN) for agitation.			ensure that the resident	•	
				duplicate therapy. Any i	ncidents of	
1	On 8/8/18 at 10:25 Al	A Numa #1 was		duplicate therapy will be	a dia auto a a di tutit	

Facility ID: 20050005

If continuation sheet Page 59 of 81

IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
345534	B. WING		C 08/09/2018	
		STREET ADDRESS, CITY, STATE, ZIP CODE	· ·	
TION CO		2702 FARRELL ROAD SANFORD, NC 27330		
TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPL	
 59 #90 on 8/4/18. She had Physician about the fall ordered Restoril and PRN cated that the Restoril was dent #90 was not sleeping a unable to find e resident was not sleeping A, Clinical Manager #2 was ed that she didn't know why ed when the resident was for insomnia. She revealed liscussed it with the A) and the PA would ril. A, the PA was interviewed. e was not aware that sleeping at night. She f she was made aware she se of the Trazodone or refer she would not order another ril. the Physician, who ordered viewed. He stated that he eceived a call from the 90 or his family member onal sleeping pill and he toril. He was not aware that dy on Trazodone and a, if he had known he would 	F 7	 Physician Assistant, or Nurse Profere recommendations. The Pharmacy Consultant will creview medication orders monthelidentify and address any duplicate and make necessary recomments the prescribing physician. In order to provide Quality Assurd Director of Nursing will audit allorders for psychotropic medicative weekly for 4 weeks, then monthelight and instances duplicate therapy. Any incidents duplicate therapy will be discuss the prescribing provider (Medica Physician Assistant, or Nurse Profere recommendations. The Director of Nursing will preseresults of these audits to the Quality Assurance Performance Improvide Committee for a minimum of the concerns, and recommendation modification of the process. The Director of Nursing will be responsible for implementing the correction. 	ontinue to ly to ate therapy indations to rance, the active ions ly for 2 s of sed with al Director, ractitioner) sent the ality ement ee y trends, s for any	
	TION CO TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 59 59 59 59 59 59 59 59 59 59	TION CO ID TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ID 59 F 75 59 F 75 490 on 8/4/18. She had e Physician about the fall ordered Restoril and PRN stated that the Restoril was dent #90 was not sleeping a unable to find e resident was not sleeping F 75 1, Clinical Manager #2 was ed that she didn't know why ed when the resident was or insomnia. She revealed iscussed it with the A) and the PA would il. In 1, the PA was interviewed. E was not aware that sleeping at night. She is he was made aware she se of the Trazodone or refer she would not order another il. The Physician, who ordered viewed. He stated that he seceived a call from the 90 or his family member nnal sleeping pill and he toril. He was not aware that dy on Trazodone and a, if he had known he would odone and not order the	TION CO STREET ADDRESS, CITY, STATE, ZIP CODE TRON TOF DEFICIENCIES ID PROVIDER'S PLAN OF CORR MUST BE PRECEDED BY FULL ID PREFIX SCIDENTIFYING INFORMATION) PT PREFIX 59 F 758 Physician Assistant, or Nurse P for recommendations. From Pharmacy Consultant will c ordered Restoril and PRN and make necessary recommendations. table to find and make necessary recommendations. are resident was not sleeping In order to provide Quality Assu are data the didn't know why and make necessary recommendations. ad that she didn't know why In order to provide Quality Assu biscussed it with the A) and the PA would a). Clinical Manager #2 was In order to provide Quality Assu biscussed it with the A) and the PA would a). Ho PA was interviewed. Was not aware that sheeping at night. She She would not order another ii. The Director of Nursing will presses of the Trazodone or refer she would not order another From the 90 or his family member From al sleeping pill and he corril. He was not aware that Steperson the secudits to the QuAlity or the process. Stereet a call from the From the 90 or his family member Fr	

Facility ID: 20050005

If continuation sheet Page 60 of 81

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY LETED	
		345534	B. WING				C 08/09/2018	
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	00/	09/2010	
SANFORD) HEALTH & REHABILIT			270	2 FARRELL ROAD			
				SA	NFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
F 758	Continued From page	e 60	F	758				
	Administrator stated	DON) were interviewed. The that she expected her doctor the medications the						
		event duplicate therapy.						
F 812 SS=E		tore/Prepare/Serve-Sanitary 2)	F	312			9/5/18	
	§483.60(i) Food safe The facility must -	ty requirements.						
	§483.60(i)(1) - Procu approved or consider state or local authorit	red satisfactory by federal,						
	(i) This may include f	ood items obtained directly subject to applicable State						
	(ii) This provision doe facilities from using p	es not prohibit or prevent produce grown in facility						
	safe growing and foo (iii) This provision do	es not preclude residents						
		Is not procured by the facility. prepare, distribute and						
	serve food in accorda standards for food se	ance with professional ervice safety.						
	by:	Γ is not met as evidenced			The facility failed to discard opened,			
	facility failed to disca items in 1 of 2 kitcher	rd opened, expired food n refrigerators and failed to is with their opened date and			expired food items in 1 of 2 refrigerators and failed to date frozen food items with their opened date and discard an expire	٦		
	discard an expired fo freezers. The finding	od product in 1 of 1 kitchen s included:			food product in 1 of 1 freezer. Items noted during survey to be expired	1		
		kitchen food storage areas 6/18 at 9:30 AM with the /) revealed:			and/or opened without a date were discarded on 8/6/18.			

Event ID: S6KG11

Facility ID: 20050005

If continuation sheet Page 61 of 81

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	IO. 0938-039
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CO	MPLETED
		345534	B. WING		0	C 8/09/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP		
				2702 FARRELL ROAD		
SANFORD	HEALTH & REHABILIT	ATION CO		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 812	Continued From page	e 61	F 81	2		
				Dietary staff failed to disca	ard expired food	
	a. Observed in the ki	tchen's walk-in refrigerator		items and failed to label ite	•	
		age of turkey with an expired		appropriately.		
	expiration date of 7/7	/18, a 5-pound container of				
		an expired expiration date of		A 100% audit of all food it		
		f opened tuna salad with an		kitchen was completed on		
		te of 8/4/18, a container of		Dietary Manager to ensure		
	opened egg salad wi	th an expired expiration date		food was discarded appro items are labeled with an		
	01 0/4/10.			During this audit, a bag of		
	b. Observation of foo	ds stored in the walk-in		and French fries were ide		
	freezer revealed an o	opened, undated package of		freezer as not labeled or c		
	chicken, an opened,	undated package of chicken		container of left over ribs	were not stored	
		Indated package of potatoes		air tight per policy. The co		
	-	d carton of frozen heavy		was issued disciplinary ac	tion per policy	
	cream with an expire	d use by date of 6/4/18.		by the Dietary Manager.		
	In an interview on 8/6	6/18 at 9:30 AM, the DM		An in-service was initiated	l by the Dietary	
	stated all items ident	ified should have been dated		Manager on 8/17/18 all die	etary employees	
	•	scarded at the time of		regarding storage of food		
		tated she assumed the DM		with professional standard		
		ks ago after the previous DM		safety. All newly hired die	•	
	÷ .	itly and she was still in the ler new role. She stated it		receive the appropriate ec orientation. Staff will not b	-	
		sponsibility to ensure there		work until they have receiv		
	-	and any staff who opened an		in-service.		
	-	to write the date opened on				
	the item.	•		When food, food products	or beverages	
				are delivered to the nursin		
				staff will inspect these iter		
				transport and quality upor		
				ensure their proper storag		
				of when to discard perisha covering, labeling, and da		
				stored in the refrigerator o	-	
				indicated. Dietary staff wil		
				receipt and storage of dry		
				foods not safe for consum	-	
				dry food products in close		

Event ID: S6KG11

Facility ID: 20050005

If continuation sheet Page 62 of 81

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					С
		345534	B. WING		08/09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SANFOR	HEALTH & REHABILIT	ATION CO		2702 FARRELL ROAD 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIN
F 812	Continued From page	e 62	F 81	2 and rotating supplies. In order to provide Quality Assu utilizing a Food Storage Audit to Dietary Manager will audit all fo areas to ensure food is stored in accordance with professional st for food safety weekly for 8 wee monthly for 1 month to identify a instances of noncompliance. Ar or opened unlabeled items will b discarded upon identification. The Dietary Manager will prese results of these audits to the Qu Assurance Performance Improv Committee for a minimum of thr consecutive meetings to identify concerns, and recommendation modification of the process.	ool the od storage n andards eks, then any ny expired be nt the uality rement ee y trends,
F 865 SS=E	CFR(s): 483.75(a)(2) §483.75(a) Quality as improvement (QAPI) §483.75(a)(2) Presen	ssurance and performance program. It its QAPI plan to the State er than 1 year after the egulation; e of information. ary may not require	F 86	The Dietary Manager will be res for implementing the plan of cor	-

Facility ID: 20050005

If continuation sheet Page 63 of 81

		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPI OMB NO. 093	
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	ΞY
		345534	B. WING		C 08/09/20	18
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	10
				2702 FARRELL ROAD		
SANFORD	HEALTH & REHABILIT	ATION CO		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMP E APPROPRIATE D	(X5) PLETION DATE
F 865	Continued From page	e 63	F 86	5		
	requirements of this s		1 00			
		section.				
	§483.75(i) Sanctions					
		by the committee to identify				
	and correct quality de	eficiencies will not be used as				
	a basis for sanctions.					
	This REQUIREMENT	Γ is not met as evidenced				
	by:					
		iew, observation, resident		The facility's Quality Assurat		
		iterview, the facility 's		Committee failed to maintain	-	
	-	and Assurance (QAA)		procedures and monitor the i		
		naintain implemented itor these interventions that		the facility put in place follow	-	
	•	to place following the 8/17/17		recertification survey on 8/17 area of Accuracy of Assessm		
		in the area of Accuracy of		following the 10/11/17 and 3/		
	-	0), following the $10/11/17$		complaint investigation surve		
	•	nt investigation surveys in the		area of Abuse and Neglect, f	-	
	-	eglect (483.12), following the		2/15/18 complaint investigati	-	
		vestigation survey in the area		the area of Pressure Ulcers,	2	
		83.25), and following the		the 3/15/18 complaint investi	-	
	3/15/18 complaint inv	vestigation survey in area of		in the area of Accident Hazar	rds.	
	Accident Hazards (48	33.25). These 4 deficiencies		A plan of correction for F641	, F600, F689,	
		he current recertification		and F686 cited during the an	nual survey	
		e continued failure of the		on 8/9/18 were submitted to	CMS on	
		ore federal surveys of record		8/28/18.		
		facility 's inability to sustain				
		ssessment and Assurance		Plans of correction were put	-	
	program. The finding	s included:		the time of each deficiency c	5	
	This tag is proce refe	rapad to:		the surveys on 8/17/17, 10/1		
	This tag is cross refe			and 2/15/18. Each plan of co		
	1 483 20 Accuracy a	of Assessments: Based on		included monitoring tools and monitoring tools during mont		
		vation, and staff interviews,		Assurance Performance Imp		
		ode the Minimum Data Set		meetings for a defined amou		
		iccurately in the areas of		Monitoring of each plan of co		
		antipsychotic medication		presented to the Quality Ass		
		B), falls (Resident #72), and		Performance Improvement C		
	-			-		
	dental status (Reside	ent #2) for 3 of 27 residents		No further issues were identi	tied	

Facility ID: 20050005

If continuation sheet Page 64 of 81

		ND HUMAN SERVICES MEDICAID SERVICES				PRINTED: 09/04 FORM APPR OMB NO. 0938	OVED
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	(
		345534	B. WING			C 08/09/201	8
NAME OF P	ROVIDER OR SUPPLIER	·	- ·	STREET ADDRESS,	CITY, STATE, ZIP CODE	-	
				2702 FARRELL RO	AD		
SANFURD) HEALTH & REHABILIT	ATION CO		SANFORD, NC 2	27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)		ETION
F 865	Continued From page	e 64	F 86	5			
				monitoring w	vas discontinued.		
		tion survey of 8/17/17 the					
	facility was cited at 4	5			ailed to maintain complian	ce	
	Assessments for failing			eviously cited and then			
		ely in the areas of active			cifically in the areas of Assessments, Abuse and		
	diagnosis and behavi	015.			essure Ulcers, and Acciden	+	
	2. 483.12 Abuse and	Neglect: Based on record		Hazards.			
		staff and resident interview,					
		otect a cognitively impaired		The Adminis	strator initiated an in-servic	e to	
	resident (Resident #6	62) from unwanted advances		all Administr	ative staff on August 28, 2	018	
		act resident (Resident #60)			uality Assurance Performa	nce	
		provide incontinent care to			nt processes including		
		ed extensive assist with			nd prioritizing quality		
	toileting (Resident #6 residents reviewed for				, systemically analyzing /stemic quality deficiencies		
		abuse and neglect.			and implementing correctiv		
	During the complaint	investigation survey of			formance improvement	0	
		vas cited at 483.12 Abuse			d monitoring and evaluatir	ng	
	and Neglect for failing	g to protect residents from			ness of corrective	-	
	staff who willfully neg	•		action/perfor	rmance improvement		
		e feeding as ordered. During			his in-service included		
		gation survey of 3/15/18 the		-	curacy of audits, extending		
		83.12 Abuse and Neglect for taff members to provide			appropriate, and reviewing ction/performance	9	
		sulting in a fall, failing to			it activities to evaluate the		
		to assess the resident for			s of each plan and revise a	as	
		the resident, and then failing			All newly hired Administrati		
	to use two staff to mo	ove the resident with a			eive the appropriate educa		
	mechanical lift.				tation. No staff will work ur	ntil	
					eceived the appropriate		
		Ilcers: Based on record		education.			
		and Wound Care Specialist,			uplity appyrance the		
		(RD), and staff interview, the de preventative measures to			uality assurance, the or will review the facility Qu	ality	
		er development to a resident			Committee Master Checklis	-	
		cer which resulted to the			ed audits monthly to ensur		
	-	ditional pressure ulcers for 1			reas noted to be deficient a		
		ts reviewed for pressure			analyzed and corrective		

Facility ID: 20050005

If continuation sheet Page 65 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/04/2018 MAPPROVED D: 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345534	B. WING				C 109/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SANFORD	HEALTH & REHABILIT	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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 865	F 865 Continued From page 65 F 865						
	ulcers (Resident #90)	l.			action implemented.		
	2/15/18 the facility wa Ulcers for failing to ob immediately initiate th ulcer on admission, fa orders before starting ulcer, failing to asses pressure ulcer, failing a pressure ulcer, failing Consultant orders of a pressure ulcer, and fa treatment to the press 4. 483.25 Accident Ha review, observation, a facility failed to provide resident who required 1 person for toileting unsupervised fall in th sampled residents rev Resident #57 experie the bathroom and sus requiring open reduct surgery (a surgical pr broken bone. During the complaint 3/15/18 the facility wa Hazards for failing to during the provision of	to prevent the worsening of ng to follow Wound Nurse a resident admitted with a ailing to consistently provide sure ulcer. azards: Based on record and staff interview, the le supervision to prevent a d the extensive assistance of from having an ne bathroom for 1 of 7			The Administrator will responsible for a plan of correction.	the	

Facility ID: 20050005

If continuation sheet Page 66 of 81

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING		C
		345534	B. WING		08/09/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•
SANFORD	HEALTH & REHABILI	TATION CO		2702 FARRELL ROAD SANFORD, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIEN	GTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 865	Continued From page	ge 66	F 86	5	
		strator during the previous	1 000		
		y of 8/17/17 or the complaint			
		of 10/11/17. She stated she			
		or at the time of 2/15/18 and			
	•	vestigation surveys. She			
		ware of the citations from			
		eys. The Administrator been no identified concerns in			
		vith MDS accuracy and she			
		why this was a repeat citation.			
	-	the previous citations in the			
		ect the Administrator indicated			
		ed the facility to develop a no			
		well as a change in leadership			
	-	gement staff to direct care this change included the			
	-	w Director of Nursing and a			
	-	Coordinator that was			
		nis month (August 2018). The			
	-	about their previous citation			
		ent/Hazards reporting that the			
	facility had recently				
		rement plan related to falls as during QAA that there had			
	-	the number of falls at the			
		that this performance			
		as still in the early stages of			
		ne reported that in regard to			
	-	elated to Pressure Ulcers that			
	•	ad a steady Treatment Nurse			
		ths reporting 4 changes in he had been the Administrator			
		he stated she believed these			
	· • •	to the repeat deficiency.			
F 881	Antibiotic Stewardsh		F 88	1	9/5/18
SS=E	CFR(s): 483.80(a)(3				
33-E		,			

		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
		345534	B. WING		C)8/09/2018	
IAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD)E	
ANFOR) HEALTH & REHABILIT			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 PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 881	Continued From pag	e 67	F 88	31		
	-	ablish an infection prevention (IPCP) that must include, at wing elements:				
	§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff,			The facility failed to follow its		
	Medical Director, the Antibiotic Stewardsh the failure to identify	nt, Physician's Assistant, and facility failed to follow its ip Program as evidenced by and address the use of tative) antibiotic prescribed s of 3 of 5 residents		Stewardship Program as evic failure to identify and address prophylactic antibiotic prescri indefinite basis for Resident # #45.	s the use of bed on an	
	(Resident #4, #44, a			Resident #4 was prescribed I eye ointment on 10/19/17 for with no stop date. Resident # prescribed prophylactic Kefle	ectropion 45 was	
	Program's policy, las appropriate indicatio included: "a. Criteria active infection or su	y's Antibiotic Stewardship trevised 12/2016, indicated ns for use of antibiotics met for clinical definition of spected sepsis; and b. lity, based on culture and		history of urinary tract infection 3/15/18 with no stop date. Re was prescribed prophylactic ⁻ related to a history of urinary infections on 3/21/18 with no	ons on esident #44 Frimethoprim tract	
	sensitivity, to antimic while culture is pend stated that if an antik	robial (or therapy begun ing)." The policy additionally piotic was ordered that a start nber of days of therapy was		Prescribing providers were no the facility's Antibiotic Stewar Program. The facility failed to track use of antibiotics. The C Pharmacist failed to track ant or make timely recommendat prescribing provider regarding	dship accurately Consultant ibiotic usage ions to the	
	2/21/17 with diagnos left and right lower e	admitted to the facility on ses that included ectropion of yelids (lower eyelid turns or from your eye, exposing the		The antibiotic prescribed for F was discontinued on 8/10/18.	nfection. Resident #4	

If continuation sheet Page 68 of 81

		ND HUMAN SERVICES				M APPROV O. 0938-03
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345534	B. WING		30	C 3/09/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
				2702 FARRELL ROAD		
SANFORD	HEALTH & REHABILI	TATION CO		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIC DATE
F 881	Continued From page	ne 68	F 88	1		
	Continued i tom pa	Je 00	F 00		tive for	
	A physician's order	for Decident #4 dated		The Responsible Representa		
		for Resident #4 dated		Resident #45 was contacted	•	
		Erythromycin (antibiotic) 0.5		the Director of Nursing regard currently prescribed antibiotic		
		tment apply 1-centimeter (cm) onjunctival sac at night related		Responsible Representative		
		was no stop date for this		educated on the risks versus		
	order.			antibiotic use in the absence		
				infection. The Responsible		
	The quarterly Minim	um Data Set (MDS)		Representative verbalized an	1	
		1/6/17 indicated Resident		understanding of education; I		
		severely impaired. She was		requests that the antibiotic no		
		otics on 7 of 7 days during the		discontinued citing that each		
		Her active diagnoses		medication has been disconti		
	included ectropion of	of left and right lower eyelids.		past, her mother has experied	nced pain	
	Resident #4 was as	sessed with no active		related to urinary tract infection	ons. Resident	
	infections.			#45 is currently on hospice se Responsible Representative		
	A Pharmacy Consul	tant recommendation dated		wishes to keep her mother co	omfortable	
		ythromycin eye ointment was		and pain free. The Medical D		
		nd no stop date was issued.		Hospice were consulted on 8		
		on was to check with the		regarding the use of prophyla		
		was able to be discontinued		antibiotics and agreed that th		
		dered with a 10 to 14-day		outweigh the risks of use in the		
		mmendation was reviewed		case as resident is on hospic		
		hysician 's Assistant (PA) on		and has not had any side effe		
	follow up appointme	ed to refer to the optometry		adverse reactions to the antik resident has not experienced		
		ant.		tract infection since initiation	•	
	The quarterly MDQ	assessment dated 5/1/18		prophylactic antibiotic. Reside		
		#4 's cognition was severely		plan updated on 8/7/18 by the		
		administered antibiotics on 7		Coordinator.		
		MDS review period. Her				
		cluded ectropion of left and		The antibiotic prescribed for I	Resident #44	
		Resident #4 was assessed		was discontinued on 8/7/18.		
				A 100% audit of all active phy		
		t #4 ' s current physician ' s		was completed on 8/21/18 by		
		ed on 8/7/18. The orders		Pharmacy Consultant to iden		
	included the Ervthro	mycin eye ointment order that		currently prescribed antibiotic	s in the	

Facility ID: 20050005

If continuation sheet Page 69 of 81

ENTERS	S FOR MEDICARE &	MEDICAID SERVICES					IO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION		TE SURVEY MPLETED
		345534	B. WING			0	C 8/09/2018
ME OF PR	OVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				27	702 FARRELL ROAD		
ANFORD	HEALTH & REHABILIT	ATION CO		S	ANFORD, 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 881	Continued From page	- 60	F 8	01			
		9/17. A further review of	ГО		absence of an active infection. One		
		d revealed there continued to			resident was noted to have an active		
	be no stop date for th				order for antibiotic eye drops without a		
	ointment.			stop date. Recommendations were ma	de		
	cilitationt.				to the prescribing provider on 8/22/18 f		
	A review of the month	nly drug regimen reviews and			the discontinuation of this medication a		
		dations for Resident #4			the medication was discontinued on		
		nention of the Erythromycin			8/23/18 per provider orders.		
		e 1/16/18 recommendation					
	to discontinue the me				The Pharmacy Consultant was in-servi	ced	
					by the Pharmacy Manager on 8/21/18		
	An interview was con	ducted with the Director of			regarding antibiotic stewardship policie	S	
		7/18 at 3:40 PM. She			and procedures. This in-service include	ed	
		sponsible for monitoring the			the requirement for the Pharmacy		
		p Program (ASP) at the			Consultant to identify and		
	-	is asked what the ASP 's			address/readdress any antibiotic		
		e use of antibiotics without			prescribed on an indefinite basis and/o	r	
	•	ctive infection. She reported			without clinical indication for use.		
		at the policy stated, but that			The Director of Number and stated as		
		cility tried to deter from the			The Director of Nursing provided an		
		preventative) antibiotics. The			in-service to the Assistant Director of Nursing and all providers including the		
		t the ASP 's policy stated piotics prescribed on an			Medical Director and in-house physicia	n	
		stated she was not sure.			assistant on 8/22/18 regarding the	1	
		ne had just taken over			facility's Antibiotic Stewardship Program	n.	
	-	SP about a month and a half			This in-service included ensuring that		
		d she needed to follow up			antibiotics are not prescribed in the		
	•	ponsible staff member to			absence of an active infection and that	all	
	provide additional info				antibiotic orders have a stop date.		
	An interview was con	ducted with the Admissions			The Assistant Director of Nursing initiat		
		8 at 3:50 PM. She stated			an in-service to all licensed nursing sta		
	-	for the ASP up until about a			and providers on 8/22/18 regarding the		
						n.	
					-		
					-	- 11	
	-					all	
	month and a half ago were expected to hav indication for use and a specified duration.	 She stated that antibiotics ye an adequate clinical d were also expected to have She revealed that an phylactically was not an 			and providers on 8/22/18 regarding the facility's Antibiotic Stewardship Program This in-service included ensuring that antibiotics are not prescribed in the absence of an active infection and that antibiotic orders have a stop date. All newly hired licensed nursing staff will	n.	

Facility ID: 20050005

If continuation sheet Page 70 of 81

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING		C
		345534	B. WING		08/09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SANFOR	HEALTH & REHABILIT	ATION CO		2702 FARRELL ROAD 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO
F 881	Continued From page	e 70	F 88		
	additionally revealed	that an antibiotic prescribed was not in accordance with		receive the appropriate education du orientation. Staff will not be allowed t work until they have received the in-service.	•
Ac Th Re 10	Admission 's Coordinator on 8/8/18 at 3:00 PM. The Erythromycin eye ointment order for Resident #4 that had been in place since 10/19/17 was reviewed with the Admission 's Coordinator. She confirmed that this order was			The Pharmacy Consultant will identified address/readdress any antibiotic prescribed on an indefinite basis and without clinical indication and make necessary recommendations to the	
	responsible for the AS	meframe that she was SP. She was unable to term use of this prophylactic en addressed.		prescribing physician. The Pharmacy Consultant will complete an exit conference with the Administrator an Director of Nursing monthly and prov complete list of all residents on antib	id <i>i</i> ide a
	at 12:20 PM. The PA s Antibiotic Stewards about the use of prop prescribed indefinitely involved in the facility unaware of the ASP	ducted with the PA on 8/9/18 was asked what the facility ' hip Program 's policy stated hylactic antibiotics y. She stated she was not 's ASP and she was s policy. She reported she e of initiating orders for		and recommendations for review. All antibiotic orders will be verified by Unit Managers x 2, Assistant Director Nursing, and Director of Nursing 5 x weekly to ensure diagnosis and stop dates.	r of
	prophylactic antibiotic a prophylactic antibio provider and there we consequences of that not usually recommended medication. The order Erythromycin eye oin since 10/19/17 was re 1/16/18 pharmacy read discontinue Resident	cs. She stated if an order for tic came from another ere no adverse t antibiotic that she would nd a discontinuation of the er for Resident #4 ' s tment that had been in place eviewed with the PA. The commendation to #4 ' s Erythromycin eye		In order to provide Quality Assurance utilizing an Antibiotic QI Audit Tool th Assistant Director of Nursing will aud active antibiotic orders weekly x 4 we then monthly x 2 months to ensure e antibiotic prescribed has a clinical indication and a stop date. The Assis Director of Nursing will notify the prescribing provider of any concerns identification.	e lit all eeks each stant
	that this was an insta antibiotic was prescri	ed with the PA. She stated nce in which the prophylactic bed by an optometrist and erse consequences, so she the antibiotic.		The Director of Nursing will be responsible for the plan of correction	

Facility ID: 20050005

If continuation sheet Page 71 of 81

		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 09/04/201 FORM APPROVE VB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		3) DATE SURVEY COMPLETED
		345534	B. WING				C 08/09/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
SANFORE	HEALTH & REHABILIT	ATION CO			2 FARRELL ROAD		
		ATEMENT OF DEFICIENCIES	ID	54	NFORD, NC 27330 PROVIDER'S PLAN OF COF		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION
F 881	Continued From page	e 71	F	881			
		as conducted with the	1	001			
		t on 8/9/18 at 1:05 PM. The					
	-	t was asked what the facility					
		ship Program 's policy					
		of prophylactic antibiotics					
	prescribed indefinitel sure what the ASP 's	y. She stated she was not					
	prophylactic antibiotic						
		rescribed with no stop date					
		or infection prevention. She					
		ntified and addressed					
		cs that were prescribed					
	, , ,	r monthly drug regimen acy Consultant stated she					
		6 months after admission					
	-	e antibiotic and would then					
	make a recommenda	ation to discontinue it if no					
	infections had occurr						
		ed 1/16/18 to discontinue the					
		Itment for Resident #4 was armacy Consultant. She					
		an instance in which she					
		4 was on a prophylactic					
	antibiotic and had no						
		continuation. She revealed					
		ther recommendations 4 ' s Erythromycin eye					
	ointment after 1/16/1						
	A phone interview wa	as conducted with the facility '					
	s Medical Director/Re	esident #4 's physician on					
		he Medical Director was					
		y 's Antibiotic Stewardship					
		ated about the use of cs prescribed indefinitely.					
		unsure of the facility 's					
		p Program 's policy. He					
		mself or his PA were in the					
	practice of prescribin	g prophylactic antibiotics as					

Facility ID: 20050005

If continuation sheet Page 72 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345534	B. WING				C 109/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SANFORI) HEALTH & REHABILITA	ATION CO			2702 FARRELL ROAD SANFORD, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 881	their use. He explain admitted on a prophy specialist prescribed sometimes didn ' t km originally initiated. He why the medication w not discontinue the m some adverse consect An interview was con Administrator on 8/9/' she expected the faci be aware of the Antib s policy, for the policy antibiotics to be admi criteria for an active in antibiotic orders to ha 2. Resident #45 was 3/14/18 with diagnose kidney disease stage palliative care. A physician ' s order of Keflex (antibiotic) 250 for prophylaxis (preve- A Physician ' s Assista indicated Resident #4 Keflex related to a his Infections (UTIs). The for discontinuation if F Responsible Party (R	e to support the benefit of ed that if a resident was lactic antibiotic or if a the medication that he ow why the medication was e stated that without knowing vas initiated that he would redication unless there was quence. ducted with the 18 at 4:10 PM. She stated lity ' s staff and providers to iotic Stewardship Program ' or to be followed, for nistered only when the effection was met, and for all twe a specified duration. admitted to the facility on es that included chronic 3, heart failure, and dated 3/14/18 indicated 0 milligrams (mg) once daily ention). ant (PA) note dated 3/15/18 45 was on prophylactic story of Urinary Tract e PA noted that she advised Resident #45 ' s	F	881			

Facility ID: 20050005

If continuation sheet Page 73 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345534	B. WING _			C 08/09/2018			
NAME OF P	ROVIDER OR SUPPLIER	L		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
SANFOR	DHEALTH & REHABILITA	ATION CO			702 FARRELL ROAD ANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 881	Continued From page	973	F 8	881				
		ated 3/21/18 indicated prophylactic Keflex related						
	#45 ' s cognition was administered antibioti	19/18 indicated Resident severely impaired. She was cs on 7 of 7 days during the Resident #45 was assessed						
	orders was conducted included the Keflex 22 prophylaxis that was review of Resident #4	#45 ' s current physician ' s d on 8/7/18. The orders 50 mg once daily for initiated on 3/14/18. A further 45 ' s record revealed there op date for the prophylactic						
		Pharmacy Consultant ssing the use of prophylactic						
	Resident #45 had bee since her admission of	3 at 1:08 PM. She reported en on prophylactic Keflex on 3/14/18. She stated active infection and that the						
	Nursing (DON) on 8/7 indicated she was res Antibiotic Stewardshi facility. The DON wa policy stated about th	ducted with the Director of 7/18 at 3:40 PM. She sponsible for monitoring the p Program (ASP) at the s asked what the ASP ' s e use of antibiotics without ctive infection. She reported						

Facility ID: 20050005

If continuation sheet Page 74 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 09/04/2018 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345534	B. WING			0	C 8/09/2018
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SANFOR	HEALTH & REHABILIT	ATION CO			2702 FARRELL ROAD SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 881	she was aware the fa use of prophylactic and asked what the ASP ' use of antibiotics pres- basis. She stated shi explained that she have responsibility of the A ago. The DON stated with the previous resp provide additional info An interview was con Coordinator on 8/7/18 she was responsible month and a half ago were expected to have indication for use and a specified duration. antibiotic ordered pro- adequate clinical indi- additionally revealed on an indefinite basis the ASP 's policy. An interview was con at 12:20 PM. The PA s Antibiotic Stewards about the use of prop prescribed indefinitely involved in the facility unaware of the ASP ' was not in the practice prophylactic antibiotic resident was admitted or if a specialist prese there had been no ad effects of it that she w	at the policy stated, but that incility tried to deter from the intibiotics. The DON was 's policy stated about the scribed on an indefinite e was not sure. She ad just taken over SP about a month and a half d she needed to follow up ponsible staff member to pormation. ducted with the Admissions 8 at 3:50 PM. She stated for the ASP up until about a b. She stated that antibiotics we an adequate clinical t were also expected to have She revealed that an phylactically was not an cation for use. She that an antibiotic prescribed was not in accordance with ducted with the PA on 8/9/18 was asked what the facility ' hip Program 's policy stated ohylactic antibiotics y. She stated she was not t' s ASP and she was s policy. She reported she we of initiating orders for cs. She explained that if a d on a prophylactic antibiotic cribed the antibiotic and liverse consequences/side	F	881			

Facility ID: 20050005

If continuation sheet Page 75 of 81

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/04/2018 // APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDI			(X3) DATE SURVEY COMPLETED		
		345534	B. WING					C 09/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP	, CODE		
SANFOR	HEALTH & REHABILITA			27	702 FARRELL ROAD			
SAN ONL				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	x	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BI		(X5) COMPLETION DATE
F 881	that had been in place reviewed with the PA. that advised a discont Keflex if the RP was a the PA. She stated sl Keflex's discontinual was on hospice and s the medication. She agreeable to its disco had not seen any adv prophylactic Keflex, s it. A phone interview was Pharmacy Consultant Pharmacy Consultant Pharmacy Consultant 's Antibiotic Stewards stated about the use of prescribed indefinitely sure what the ASP 's prophylactic antibiotic prophylactic antibiotic indefinitely during her reviews. The Pharma normally waited 4 to 6 and/or initiation of the make a recommendations rela- prophylactic Keflex.	At #45 's prophylactic Keflex e since 3/14/18 was Her note dated 3/15/18 tinuation of Resident #45 's agreeable was reviewed with he had advised for the tion because Resident #45 the had not seen a benefit of indicated the RP was not intinuation. She stated she erse consequences of the o she had not discontinued s conducted with the ton 8/9/18 at 1:05 PM. The twas asked what the facility ship Program 's policy of prophylactic antibiotics to She stated she was not policy stated about s, but that generally escribed with no stop date r infection prevention. She tified and addressed s that were prescribed monthly drug regimen acy Consultant stated she to months after admission antibiotic and would then tion to discontinue it if no ed. The order for Resident eflex that had been in place riewed with the Pharmacy irmed she had made no ated to Resident #45 's	F	881				
	A phone interview wa	s conducted with the facility '						

If continuation sheet Page 76 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMF	E SURVEY PLETED
		345534	B. WING				09/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SANFOR) HEALTH & REHABILITA	ATION CO			2702 FARRELL ROAD SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 881	 8/9/18 at 3:05 PM. TI asked what the facility Program 's policy staprophylactic antibiotic He revealed he was u Antibiotic Stewardship stated that neither him practice of prescribing there was no evidence their use. He explaine admitted on a prophyl specialist prescribed to sometimes didn 't knooriginally initiated. He why the medication w not discontinue the m some adverse consect An interview was come Administrator on 8/9/7 she expected the facility antibiotics to be admit criteria for an active ir antibiotic orders to ha 3/21/18 with diagnose and hypertension. Resident #44 's histo 3/21/18 completed prifacility indicated she further that the facility indicated she further that the system of the syste	esident #45's physician on he Medical Director was y's Antibiotic Stewardship ted about the use of is prescribed indefinitely. unsure of the facility's o Program's policy. He nself or his PA were in the g prophylactic antibiotics as e to support the benefit of ed that if a resident was lactic antibiotic or if a the medication that he ow why the medication was e stated that without knowing vas initiated that he would edication unless there was quence. ducted with the 18 at 4:10 PM. She stated lity's staff and providers to iotic Stewardship Program' to be followed, for nistered only when the nfection was met, and for all we a specified duration. admitted to the facility on es that included Alzheimer's rry and physical dated ior to her admission to the had a history of recurrent hs (UTIs) and was on ative) antibiotics. Resident	F	88			

Facility ID: 20050005

If continuation sheet Page 77 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	
			A. BUILDI	NG.			с
		345534	B. WING			08/	09/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SANFOR	HEALTH & REHABILITA	ATION CO			2702 FARRELL ROAD SANFORD, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 881	Continued From page	277	F	881	1		
	Trimethoprim (antibio	dated 3/21/18 indicated tic) 100 milligrams (mg) nt #44. There was no stop					
		ant (PA) note dated 3/22/18 4 was on prophylactic story of UTIs.					
		ated 3/26/18 indicated Trimethoprim for recurrent					
	#44 ' s cognition was administered antibioti	26/18 indicated Resident severely impaired. She was cs on 7 of 7 days during the Resident #44 was assessed					
	orders was conducted included the Trimetho UTI prophylaxis that v	-					
		Pharmacy Consultant ssing the use of prophylactic					
	Resident #44 had bee Trimethoprim since he	3 at 11:53 AM. She reported					

Facility ID: 20050005

If continuation sheet Page 78 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345534	B. WING				09/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SANFOR	HEALTH & REHABILIT	TION CO			702 FARRELL ROAD ANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 881	stop date. An interview was con Nursing (DON) on 8/7 indicated she was res Antibiotic Stewardship facility. The DON wa policy stated about th the presence of an ac she was not sure wha she was not sure wha she was aware the fa use of prophylactic ar asked what the ASP ' use of antibiotics pres basis. She stated she explained that she ha responsibility of the A ago. The DON stated with the previous resp provide additional info An interview was con Coordinator on 8/7/18 she was responsible month and a half ago were expected to hav indication for use and a specified duration. antibiotic ordered pro adequate clinical india additionally revealed on an indefinite basis the ASP ' s policy. An interview was con at 12:20 PM. The PA	prim was prescribed with no ducted with the Director of 7/18 at 3:40 PM. She sponsible for monitoring the o Program (ASP) at the s asked what the ASP ' s e use of antibiotics without ctive infection. She reported at the policy stated, but that cility tried to deter from the ntibiotics. The DON was s policy stated about the scribed on an indefinite e was not sure. She d just taken over SP about a month and a half d she needed to follow up bonsible staff member to ormation. ducted with the Admissions 8 at 3:50 PM. She stated for the ASP up until about a . She stated that antibiotics e an adequate clinical were also expected to have She revealed that an phylactically was not an cation for use. She that an antibiotic prescribed was not in accordance with	F	881				

If continuation sheet Page 79 of 81

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE SUR	938-039
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETI	
					с	
345534					08/09/2	2018
NAME OF PI	ROVIDER OR SUPPLIER	•	- I	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
				2702 FARRELL ROAD		
SANFURL	HEALTH & REHABILIT	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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE CO	(X5) OMPLETIO DATE
F 881	Continued From pag	e 79	F 88	1		
1 001		y. She stated she was not	F 00			
		y's ASP and she was				
		's policy. She reported she				
		ce of initiating orders for				
		cs. She explained that if a				
	resident was admitte	d on a prophylactic antibiotic				
	or if a specialist pres	cribed the antibiotic and				
		dverse consequences/side				
	effects of it that she v	-				
		tinuation of the medication.				
		nt #44 ' s prophylactic				
		d been in place since				
		d with the PA. She stated ince in which Resident #44				
		ctic antibiotic prior to her				
	admission and she h					
		he had not discontinued the				
	antibiotic.					
		as conducted with the				
		t on 8/9/18 at 1:05 PM. The				
		t was asked what the facility				
		ship Program 's policy				
		of prophylactic antibiotics y. She stated she was not				
	sure what the ASP 's					
	prophylactic antibioti					
		rescribed with no stop date				
		or infection prevention. She				
		ntified and addressed				
	prophylactic antibioti	cs that were prescribed				
		r monthly drug regimen				
		acy Consultant stated she				
	-	6 months after admission				
		e antibiotic and would then				
	make a recommenda	ation to discontinue it if no				
	infections had occurr	ed. The order for Resident rimethoprim that had been				

Facility ID: 20050005

If continuation sheet Page 80 of 81

ID SERVICES //DER/SUPPLIER/CLIA fiFICATION NUMBER: 345534 PF DEFICIENCIES PRECEDED BY FULL FYING INFORMATION) Philippe She had lated to Resident	A. BUILDING B. WING 2	E CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE 702 FARRELL ROAD SANFORD, NC 27330 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X3) DATE COMP (08/ BE	0. 0938-0391 SURVEY LETED C 09/2018 (X5) COMPLETION DATE
PF DEFICIENCIES PRECEDED BY FULL FYING INFORMATION)	ID PREFIX TAG	702 FARRELL ROAD SANFORD, NC 27330 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	08/	09/2018 (X5) COMPLETION
PF DEFICIENCIES PRECEDED BY FULL FYING INFORMATION)	ID PREFIX TAG	702 FARRELL ROAD SANFORD, NC 27330 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	I BE	(X5) COMPLETION
OF DEFICIENCIES PRECEDED BY FULL FYING INFORMATION)	ID PREFIX TAG	SANFORD, NC 27330 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
PRECEDED BY FULL FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
PRECEDED BY FULL FYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
	F 881			DATE
rim.				
ted with the facility ' 44 's physician on al Director was biotic Stewardship t the use of bed indefinitely. the facility 's m 's policy. He is PA were in the actic antibiotics as bort the benefit of a resident was ibiotic or if a cation that he he medication was hat without knowing ed that he would n unless there was ith the B PM. She stated aff and providers to vardship Program ' lowed, for only when the vas met, and for all cified duration.				
	rim. ted with the facility ' 44 's physician on al Director was biotic Stewardship t the use of bed indefinitely. the facility 's n 's policy. He is PA were in the actic antibiotics as bort the benefit of a resident was ibiotic or if a cation that he ne medication was hat without knowing ed that he would unless there was ith the B PM. She stated off and providers to vardship Program ' lowed, for only when the was met, and for all	rim. ted with the facility ' 14 's physician on al Director was biotic Stewardship t the use of bed indefinitely. the facility 's n 's policy. He is PA were in the actic antibiotics as bort the benefit of a resident was ibiotic or if a cation that he ne medication was hat without knowing ed that he would unless there was ith the B PM. She stated of and providers to vardship Program ' lowed, for only when the vas met, and for all	ted with the facility ' t4 's physician on al Director was iotic Stewardship t the use of bed indefinitely. the facility 's n 's policy. He is PA were in the actic antibiotics as iotit the benefit of a resident was ibiotic or if a cation that he ne medication was hat without knowing ed that he would unless there was ith the B PM. She stated iff and providers to vardship Program ' lowed, for only when the was met, and for all	rim. ted with the facility ' t4 's physician on al Director was biotic Stewardship t the use of bed indefinitely. the facility 's n 's policy. He is PA were in the actic antibiotics as biotic or if a cation that he he medication was hat without knowing ed that he would unless there was it the 8 PM. She stated of an providers to vardship Program ' lowed, for only when the was met, and for all

Facility ID: 20050005

If continuation sheet Page 81 of 81