		ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVED O. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G		IPLETED
						С
		345534	B. WING		1 <sup>,</sup>	1/28/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
SANFORE	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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	00		
	on 11/14/18 through review decided that a and the survey team	ation survey was conducted 11/16/18. Management n immediate jeopardy exited went back to the facility on on 11/28/18. Immediate ed at:				
	CFR 483.10 at tag F6 of J	600 at a scope and severity				
	CFR 483.35 at tag F7 of J	25 at a scope and severity				
	Tag F600 constituted Care	Substandard Quality of				
	Immediate jeopardy t removed on 11/28/18	began on 9/26/18 and was				
F 600	through 11/28/18	conducted on 11/27/18	F 6(	00		12/12/18
SS=J		Negleci	FO			12/12/16
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to edical symptoms.				
	§483.12(a)(1) Not use	e verbal, mental, sexual, or				
		SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					12/07/2018

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.

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/27/201 MAPPROVE <u>D. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		345534	B. WING		11	C / <b>28/2018</b>
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
			2702 FARRELL ROAD			
SANFORD	HEALTH & REHABILIT	ATION CO		SANFORD, NC 27330		
(X4) ID PREFIX TAG	X         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         (EACH CORRECTIVE AC CROSS-REFERENCED TO		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 1	F 60			
	physical abuse, corpo		1 00			
	involuntary seclusion	•				
	•	, is not met as evidenced				
	by:					
		iew, observation and staff,		Address how corrective action		
		PA) and Geriatric Nurse		accomplished for those reside		
		terview, the facility failed to		have been affected by the def	icient	
		paired residents from		practice;		
	reviewed for abuse (F	of 3 sampled residents		On 9-26-18, Resident #3 was	put on $O_{15}$	
		s cognitively impaired and		minute checks. She was mor	•	
		sive behaviors towards other		the charge nurse until 9/28/18	•	
		n Resident #9 (who was		hours/7 days a week due to c		
	cognitively impaired)	with a call bell on 9/26/18		roommate, attempting to hit st		
		air on Resident #2 (who was		hitting roommate with call bell		
		and had punched her on the		time, roommate was moved o		
		causing a red spot on		Resident #3 room, Seroquel 5		
	Resident #2's leg. Re	was verbally abusive to		mouth at 1pm and Seroquel 1 mouth at 7PM were initiated b	• •	
		ed Resident # 1 (who was		PA. An order for Ativan 0.5 m		
		with a walker causing		PRN for anxiety/ agitation and	• •	
	Resident #1 to fall an			and Psychological Symptoms		
	fracture on 10/28/18.			was initiated if resident was u		
				9pm and 2am x 12 days. On 9	9-27-18,	
		began on 9/26/18 when the		Resident #3 was moved into a		
	•	ct Resident #9 from abuse		room. On 9/28/18 resident wa		
	-	ailed to manage Resident g her to abuse another		argumentative with another re	-	
		2) on 10/9/18. The facility		out medications and refused r medications.	Emanuel UI	
	-	Resident #1 from abuse by		No noted behaviors until 10-7	-18. when	
		Resident #1 to fall and		resident yelled at another resi		
	fractured her hip on 1	0/28/18. Immediate		snatched a cup out of residen		
		ed on 11/28/18 when the		residents were separated by s		
	facility provided an ad	-		redirected. On 10-8-18, new		
	allegations. The facil			Haldol 0.5mg by mouth at bec		
		r scope and severity of D		ordered due to increasing beh		
		al for more than minimal ediate jeopardy) to ensure		to resident yelling at a resider 10-7-18.		
		but into place are effective.		On 10-9-18, at 2:00PM Reside		

Facility ID: 20050005

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/27/20 M APPROV <u>D. 0938-03</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	Сом	E SURVEY PLETED C
		345534	B. WING				/28/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SANFORD	) HEALTH & REHABILIT	ATION CO			02 FARRELL ROAD ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 600	Continued From page	e 2	F	500			
	Findings included:				picked up a chair and threw it at Res # 2, then proceeded to punch Reside in her arm when she got up out of he	ent #2	
	1. Resident #3 was a 8/1/18 with multiple d Alzheimer's disease a				chair to walk away. Home Health Certified Nursing Assistant witnessed incident and Resident #3 was immed		
	admission Minimum I dated 8/8/18 indicate	ces and agitation. The Data Set (MDS) assessment d that Resident #3 had			separated by the aides and removed the charge nurse from Resident # 2 placed Resident # 3 on 1:1 until she	and was	
		airment and she had ehavioral symptoms and #3 resided in the memory			transported to the hospital via facility transport and sitter on 10/10/18. An assessment was done by the Nurse Resident # 2, and noted a red mark her leg. Police were called by the D	on on	
	that Resident #3 had and she had threaten staff. On 8/10/18, Re	an dated 8/6/18 indicated behaviors of yelling, cursing led and attempted to hit sident #3 was aggressive and other residents. A one			2:20 PM and both residents were interviewed by the officer. Neither resident was able to explain what happened as both Brief Interview for Mental Status scores are 0. Both		
	on one sitter was pro 8/14/18. The approa	vided from 8/10/18 through ches included to approach nd positively, Social Worker			Responsible Person and Physician with a made aware of the incident by the U Manager. Skin checks were obtained	nit	
	(SW) to evaluate and needed, monitor and	visit the resident as document resident's and report increase in			the Unit Manager on all residents re- in the memory care unit. No abuse v reported or assessed. Psychiatric Physician Assistant was	siding was in	
	Resident # 2 was adr 3/21/18 with multiple Alzheimer's disease.				house during the time of the incident 10-9-18. Psychiatric PA reviewed Resident #3's medications and made changes to include discontinuation of	e	
	assessment dated 9/ Resident #2 had seve had no behaviors. R				Haldol, order for Ativan 0.5 mg every hours as needed, discontinuation of Seroquel 150mg daily at 1pm, start	/ 6	
	memory care unit.	an dated 9/24/18 indicated			Seroquel 100mg at bedtime. Psychi PA noted in note that no incidents sin 9-26-18 and the increase of Seroque	nce	
	that she was a wand included to observe t	erer. The approaches he resident's whereabouts			The event occurred due to interventi put in place failed to prevent Reside	ons	
	when out of bed and	to redirect resident as			from having behaviors.		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/27/2018 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
		345534	B. WING			C 28/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
SANFOR	HEALTH & REHABILIT			270	2 FARRELL ROAD		
JANFORL				SA	NFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From page	e 3	F 6	00			
	indicated and as need				100% skin assessment of all resident the secured memory care unit was	ts in	
	The psychiatric notes for Resident #3 were reviewed. The notes dated 8/8/18 revealed that Resident #3 continued to have aggressive and combative behaviors. She was hitting staff and other residents. The plan was to discontinue the Haldol (antipsychotic drug) and to increase Seroquel (antipsychotic drug) and to add Ativan (antianxiety drug) as needed for agitation. The notes dated 9/18/18 revealed that Resident #3 had episode of insomnia along with agitation, complaining about her roommate, telling her to get out of her room. There was an addendum note dated 9/26/18 which indicated that the nurse had called and reported that Resident #3 was up during the night and was agitated with the roommate. Later on she was found beating her roommate with her call bell. The roommate was not injured as she was under her blankets. They were separated and her medications were changed. The dose of her Seroquel was increased. The notes dated 10/9/18 revealed that the GNP had observed Resident #3 sitting at the				completed by the Unit Managers on 10-9-18 No concerns were identified. 100% Resident Representative intervi- were completed for the locked unit residents by the Social Worker, Unit Managers, Director of Nursing, Media Records, Maintenance Director, Dieta Manager, Admissions, Business Offic Minimum Data Set Nurse, Activities. concerns from voiced from interviews Example of Interview Questions: Do feel the resident been harmed by and resident in the facility? If yes, was fa made aware? Do you feel resident is in the facility? A 100% all staff In-service was initiat 10-9-18 on abuse Prevention/Interve by the Director of Nursing. The in se included prevention of resident abuse and recognizing signs and symptoms abuse, dementia protocol, behavioral assessment, intervention and monito and behavioral management to include	views cal ary ce, No s. you other cility s safe ed on ntion ervice e, s of l ring de	
	food. The notes reverses several altercations were resulting in a minor leincrease her Seroque note indicating that the (DON) had called inforrequired one on one swanted to send Reside hospital. The GNP here Seroquel to Risperda had increased the Ati	d kill her if she touched her ealed that Resident #3 had with other residents and one eg injury. The plan was to el. There was an addendum he of Director of Nursing forming her that Resident #3 sitter and that the DON dent #3 out to a psychiatric ad changed Resident #3's I (antipsychotic drug)) and van as needed.			updating of plan of care. The In servi was completed by 10/11/18. On 10-28-18, Residents #1 and #4 w immediately separated by staff. Res #4 was immediately placed on a 1:1 secondary to knocking Resident # 1 down. Resident #4 was reassessed Brief Interview for Mental Status and proper placement in the memory care unit. Resident # 4 was moved to a ro out of the memory care unit with a 1: sitter in an effort to decrease her agit and her care plan was updated to ref changes. Resident # 1 was immedia	ere sident sitter for e bom 1 ation lect	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/27/2018 MAPPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345534	B. WING _	B. WING			C 28/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
0.000				27	02 FARRELL ROAD		
SANFUR	) HEALTH & REHABILIT/	ATION CO		S	ANFORD, NC 27330		
(X4) ID PREFIX TAG				K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	notes dated 9/26/18 a Resident #3 had an e aggressive behavior f was determined that roommate in her roor the whole room was I She was cursing and roommate. She beca She attempted to hit bedside commode. F calm down. Afterwar her room and her roo curtain was pulled to the room and go to be Resident #9 to ring th minute check was co #3. Resident #9 rang and Resident #3 was Resident #9. Reside out of the wall and wa it. Resident #3 was r was brought to the nu up until 3 AM when s brought back to her b continued and the ps notified. The nurse's PM revealed that Res resident #3 snatched resident #3 snatched resident *3 snatched resident saying "give me r Resident *3 snatched resident saying room another resident (Res purse. Resident #3 p	at 8:50 PM revealed that episode of agitation and throughout the shift. She she didn't want her n. She had it in her head hers and belonged to her. being disrespectful to her ame combative with staff. the nurse aide with her Resident #3 was left alone to ds, she was reoriented to mmate (Resident #9). The allow Resident #9 to enter ed. Nurse 2 instructed he call light if needed. A 15 nducted to monitor Resident g the call light at 12:15 AM observed standing over nt #3 had pulled her call bell as striking Resident #9 with emoved from the room and urse's station. She stayed he became sleepy and was hed. A 15 minute check was ychiatric services was notes dated 10/7/18 at 6:25 sident #3 was yelling at other she stole her water pitcher. as explaining that it was not a became agitated yelling at my damn cup back".	F	600	assessed and found to be in pain and unable to bear weight. XRAY was or for Resident # 1. Resident # 1 was fo to have a hip fracture, and transported the hospital on 10-28-18. 100% skin audit was completed by the unit manager and charge nurse on all residents in the secured memory care on 10-28-18, no concerns identified. 100% Resident Representative interv were completed for the locked unit residents by the Social Worker, Unit Managers, Director of Nursing, Medic Records, Maintenance Director, Dieta Manager, Admissions, Business Offic Minimum Data Set Nurse, Activities. concerns from voiced from interviews Example of Interview Questions: Do feel the resident has been harmed by another resident in the facility? If yes was facility made aware? Do you fee resident is safe in the facility? The event occurred as staff did not document and report increasing beha as reported during the investigation. staff interviewed during complaint sur on 11/14-11/16 reported Resident #4 increasing verbal aggression towards others, though the documentation in t resident chart does not reflect any concerns. A 100% all staff In Service was condu- by the Director of Nursing on 10-28-13 include abuse and neglect, signs and symptoms of abuse and prevention of abuse, proper documentation of problematic behavior to include onset frequency and precipitating factors. Address how the facility will identify of	dered und d to e unit iews al ry e, No you you you i viors The vey with he cted 3 to	

Facility ID: 20050005

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						<u>NO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			TE SURVEY
			A. BUILDING	3		С
		345534	B. WING			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		1/28/2018
	NOVIDEIN ON SUIT LIEN			2702 FARRELL ROAD		
SANFOR	DHEALTH & REHABILIT	ATION CO		SANFORD, NC 27330		
						0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 600	Continued From page	e 5	F 60	00		
	#2 tried to walk away	, Resident #3 balled her fist		residents having the potentia	l to be	
		n her right shoulder. The		affected by the same deficier		
		ed and Resident #3 was		On 11/21/18 100% audit by the	•	
	immediately redirecte	ed to her room where one on		managers and DON of all cu		
	one sitter was provide	ed.		notes were reviewed back to		
				effectiveness of interventions		
		ted 10/9/18 was reviewed.		put in place regarding behavi		
		that Resident #3 was noted		Changes in plan of care were		
	-	n the television/dining room.		they were identified during th		
	Resident #3 stated "s	-		Address what measure will b	•	
		ent #3 was observed to take		place or systemic changes m		
		t another resident (Resident resident (Resident (Resident #2)		ensure that the deficient prac	slice will not	
	· ·	ent #3 balled her and hit her		An in service on behavior ma	inagement	
	-	dents #2 and #3 were		was initiated on 11/24/18 by		
		ent #3 was taken to her		100% all nursing staff to inclu		
		one sitter was initiated as well		licensed nurses and certified		
	as psychiatric service			assistants to include interven	0	
				monitoring residents, and do	cumentation	
		ation of the incident dated		of interventions and behavior	rs and	
		ed. The investigation		reporting to the on call nurse		
		/18 at 2:30 PM, Resident #3		behaviors that show signs of		
		ner resident (Resident #2).		other residents, staff, or self-		
	-	ot up to walk away, Resident		Indicate how the facility plans		
	-	r right arm. Residents #2		its performance to make sure		
		ed immediately. Both he memory care unit. An		solutions are sustained: and		
		ne memory care unit. An pleted on Resident #2 with		when corrective action will be Beginning 11/21/18, Utilizing		
		ited. The responsible parties		documentation flowsheet au		
		re of the incident. Skin		Unit Managers, RN Supervis		
		d on all residents residing in		and/or DON reviewed progre		
		with no injuries noted. RPs		24 hour report sheets during		
		viewed and no reports of		meeting 5 x weekly x 12 wee		
		psychiatric services was		reported behaviors of reside	-	
		sident #3's medications were		require intervention of service		
	reviewed and change	es were made accordingly.		changes in staffing ratio base		
		ory of behaviors and had		resident needs and behaviors		
		psychiatric services with no		be reviewed daily by the DO		
	improvement. Reside	ent #3 was sent for		Supervisors, Unit Managers	or	

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			()() · · · ·		OMB NO. 09		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURV COMPLETE		
					С		
		345534	B. WING		11/28/20	018	
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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COM	(X5) MPLETIO DATE	
F 600	Continued From page	e 6	F 60	0			
	order due to ongoing	chiatric hospital per doctor's violence towards staff and stigation was completed on on of abuse was		Administrator. The results will b presented to the Quality Assura Committee monthly x 3.	-		
	the 5 day report that	at was sent on 10/9/18 and was sent on 10/16/18 were ation of resident abuse on stantiated.					
	was reviewed. The st Nurse Aide (NA) #4 ( agency) who was a s the memory care unit that Resident #3 took threw it at Resident # right leg. Then as Re	n statement from the witness (undated) iewed. The statement was written by ide (NA) #4 (employed by home health who was a sitter of another resident in nory care unit. The statement indicated sident #3 took a chair on 10/9/18 and at Resident #2 and the chair hit her in the . Then as Resident #2 walked away, ht #3 punched Resident #2 in the right r.					
	11/14/18 at 11:46 AM worked 7A-7P shift in indicated that Reside physically and verbal residents when first a services began worki improvement on her to 10/9/18 after lunch, F agitated. She was in with Resident #2. Nut the nurse's station wh commotion. She wer	the television/dining room rse #1 stated that she was at hen she heard the ht to the television/dining					
	room and NA #4 infor was agitated, picked Resident #2 hitting he	rmed her that Resident #3 up a chair and threw it at er right leg. When Resident sident #3 punched her on her					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 12/27/2018 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345534	B. WING				C / <b>28/2018</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SANFORD	HEALTH & REHABILIT			2	2702 FARRELL ROAD		
				5	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 600	noticed a red spot on An interview with Nur conducted on 11/14/1 stated that she was a memory care unit. SI was mean, and she th residents saying "I wi verbally abusive to st stated that she had in tried to redirect Resid displaying behaviors. An interview with NA 11/14/18 at 1:16 PM. memory care unit. SI was mean and hatefu NA #1 stated that on the unit and they wer She heard a commoti room. NA #4 who wa room had witnessed I chair and threw it at F punched her when sh stated that the nurses #3's behavior and wh #3 having behaviors, down and had to redi residents. An interview with NA	e #1 stated that she 2 after the incident and she her right leg. se Aide (NA) # 2 was 8 at 12:05 PM. NA #2 ssigned to work in the ne stated that Resident #3 hreatened staff and Il knock you out". She was aff and residents. NA #2 formed the nurses and had ent #3 when she was #1 was conducted on NA #1 was assigned in the ne stated that Resident #3 il. She was very combative. 10/9/18, there were 2 NAs in e busy passing lunch trays. ion in the television/dining resident #3 picked up a Resident #2 and then ne tried to walk away. NA #1 s were aware of Resident she had tried to calm her rect her away from other #4 was conducted on	F	600			
	sent by the home hear resident in a memory she was sitting in the the resident. She obs	NA #4 stated that she was alth agency to sit with a care unit. She stated that television/dining room with served Resident #3 agitated t book. Suddenly, she					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		345534	B. WING				C 28/2018
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	20/2010
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 APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	hitting her right leg an get up to walk away, I Resident #2 on her rig that there were no sta television/dining room busy passing the tray room. She immediate and #3 before the sta room. NA #4 stated th provoke Resident #3. sitting in the dining tal An interview was con- 11/15/18 at 10:05 AM expected the resident be safe. An interview with the conducted on 11/15/1 stated that she was in there was no contact to Resident #2 by Res that she didn't know th the incident who obse chair at Resident #2 h On 11/15/18 at 2:50 F interviewed. She stat following Resident #3 combative behaviors. her medications by in Seroquel and adding indicated that the staf were good on non- ph like redirection, keepi	threw it at Resident #2 d when Resident #2 tried to Resident #3 punched ght shoulder. NA #4 stated off member present in the h. The nurse's aides were s on the other hall dining ely separated Residents #2 ff members came to the hat Resident #2 did not Resident #2 was quiet ble. ducted with the PA on . The PA indicated that she is in the memory care unit to Unit Manager (UM) was 8 at 11:56 AM. The UM formed by Nurse #1 that when the chair was thrown sident #3. She indicated hat there was a witness to erved Resident #3 threw a hitting her right leg. PM, the GNP was ted that she had been due to her aggressive and She had made changes to creasing the dose of the Ativan. The GNP further f in the memory care unit harmacological approaches ing them busy, playing music then they were agitated.	F	600			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	
		345534	B. WING				C 28/2018
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SANFORD	HEALTH & REHABILITA	ATION CO			702 FARRELL ROAD SANFORD, NC 27330		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE		
F 600	the residents safe. On 11/27/18 at 12:53 interviewed. Nurse #2 - 7A in the memory ca to Resident #3 on 9/2 agitated that evening PM. Resident #3 was recognize her roomm indicated that she had placed her call bell wi her to call when need that when the call ligh room of Resident #3 a #3 standing over Res covered up with a bla bell in her hand and w Nurse #2 reported that of the room into the n became sleepy and th bed. Nurse #2 stated aware of Resident #3 2. Resident #4 was an 7/25/16 with multiple dementia without beh agitation and delusion MDS assessment dat Resident #4's cognitic behavior. Resident # care unit. Resident # 1 was adm 10/25/18 with multiple Alzheimer's disease.	N stated that her mory care unit was to keep PM, Nurse #2 was 2 stated that she worked 7P are unit. She was assigned 26/18. Resident #3 was when she came to work at 7 is confused and she didn't ate (Resident #9). Nurse d placed Resident #9 to bed, ithin reach and instructed led. Nurse #2 further stated at came on, she came to the and #9, and found Resident ident 9 who was in bed nket. Resident #3 had a call was beating Resident #9. at she took Resident #3 out urse's station until she hen she was placed back in I that the Unit Manager was 's behavior dmitted to the facility on diagnoses including havioral disturbances, hal disorder. The quarterly ted 9/4/18 revealed that on was intact and had no 4 resided in the memory nitted to the facility on e diagnoses including There was no admission	F	600			
	Alzheimer's disease.						

Facility ID: 20050005

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		345534	B. WING				C / <b>28/2018</b>
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	s	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	yet. Resident #1 resident #1 resident #1 resident #1 resident #1 was approaches included whereabouts frequent redirect for safety as a Resident #1's nurse's notes dated 10/25/18 Resident #1 was alert dated 10/27/18 at 4:0 #1 was able to ambul locked unit. The note PM revealed that Resion another resident #1 of #1 hit her left shoulde fell onto her left side. extend her leg and shr range of motion. The Resident #1 to stand to bear weight on her complained of pain or was notified and he o femur/hip. The result fracture of left femur. discharged to the hos Resident #4's nurse's 7:58 PM revealed that room when Resident #2 mushing Resident #2	ded in the memory care unit. dated 10/25/18 revealed a wanderer. The to monitor resident's tly and to intervene and needed. ne	F	600			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345534	B. WING				C 28/2018
NAME OF P	ROVIDER OR SUPPLIER		•	5	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 600	doorway of another re #4). Resident #4 pusher to fall. Resident #4 left leg/hip. The hospital discharg was reviewed. The d that Resident #1 had brought to the emerge home following a fall. pain in her left hip and Left hip x-ray was dor left femoral fracture. and she underwent left The psychiatric notes 10/30/18 were review Resident #4 had dem continued to have del live person. The note requested a psychiatr pushed her walker pur resident causing the r her hip. Resident #4 incident. The Staff re could be bossy and p residents but has new Resident #4 was also people" and had beer residents and staff. The facility's investiga was reviewed. The re Director of Nursing (D at approximately 4:30 #4 had pushed Resid #1 had witnessed Resident	hat Resident #1 entered the esident's room (Resident hed Resident #1 causing 1 complained of pain on her e summary dated 10/29/18 ischarge summary revealed severe dementia and was ency room from a nursing Resident #1 complained of d had difficulty ambulating. he at the facility showing a Resident #1 was admitted ft hip surgery. of Resident #4 dated ed. The notes revealed that entia and delusions and she usions of her doll being a s indicated that the staff had ic visit as Resident #4 had	F	600			

Facility ID: 20050005

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/27/2018 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345534	B. WING		1.	C 1/28/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	
SANFOR	D HEALTH & REHABILIT		2	2702 FARRELL ROAD		
			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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 600	the front of Resident Resident #4 took her Resident #1, causing report revealed that F shoulder on the door side. Resident #1 an immediately. Reside found to be in pain ar The attending physic (RP) were contacted. for an x-ray to left fen x-ray result revealed Resident #1 was sen The psychiatric servic updated on the incide RPs were contacted a were no abuse allega percent (100%) skin a to all residents residin When interviewed, R Resident #1 stating th all but the incident wa Resident #4 had histo with other residents a wandering. A 24 hou Resident #4 and she memory care unit wit The investigation was the incident was subs The 24 hour report that reviewed and the alle Resident #4 was sub An interview with NA 11/14/18 at 12:05 PM that Resident #4 was	#4's doorway, when walker and pushed it into Resident #1 to fall. The Resident #1 hit her left jam and falling on her left d #4 were separated nt #1 was assessed and nd unable to bear weight. ian and the responsible party The physician had ordered nur/hip on Resident #1. The a fracture to the left femur. t to the hospital at 8:10 PM. ces was contacted and ent with Resident #4. All and interviewed and there ations reported. Hundred assessment was conducted ng in the memory care unit. esident #4 denied pushing nat she was not involved at as witnessed by Nurse #1. ory of becoming aggravated and she had history of ir sitter was assigned to was moved out of the h wander guard on 10/28/18. s completed on 11/2/18 and estantiated.	F 600			

Facility ID: 20050005

If continuation sheet Page 13 of 30

		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/27/2018 APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345534	B. WING		_		C 28/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
				2702 FARRELL ROAD			
SANFORD	HEALTH & REHABILITA	TION 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 CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page threatening other resisenter her room. NA #2 were informed and we behavior. An interview was come PM with NA #1. NA #1 memory care unit (MC normally was schedul 10/28/18 she was ask #1 indicated that Resis she wandered. Resis oriented with some co abusive to staff and re want anybody on her wound have argument #1 stated that she trie away from Resident # An interview was come PM with Nurse #1, as stated that Resident # and was a wanderer. oriented, she didn't wa near her room. She w and other residents. 3 witnessed Resident # pushed other resident cause them injuries o that on 10/28/18 at 4: Resident #1 standing	sc IDENTIFYING INFORMATION) a 13 dents when they tried to 2 stated that the nurses ere aware of Resident #4's ducted on 11/14/18 at 1:16 I was assigned in the CU). She stated that she ed to work 7-3 shift but on ted to stay over to help. NA dent #1 was confused and dent #4 was alert and onfusion and verbally esidents. Resident #4 didn't space and occasionally, she ts with her roommate. NA d to redirect other residents		CROSS-REFEREI	NCED TO THE APPROPRIA		DATE
	Resident #1. Resider the door frame and th When Resident #1 wa was observed pushing #1 trying to close the that when she intervie	as on the floor, Resident #4 g the door against Resident door. The nurse indicated ewed Resident #4, Resident esident #1 but she admitted					

Facility ID: 20050005

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED
		345534	B. WING				C / <b>28/2018</b>
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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	that she was trying to didn't want to be invo Nurse #1 stated that s nurse's station when could see the doorwa further indicated that followed by the psych management of her b The Nurse stated that trying to redirect othe room. On 11/14/18 at 4:23 F observed in bed and that Resident #1 was she told her "no". Re the door on her face" anybody in her room. On 11/15/18 at 10:05 interviewed. She state the incident that occu #4. The PA indicated residents in the memo On 11/15/18 at 11:15 (SW) was interviewed responsible for assess on the MDS assessm that Resident #4's cop had a Brief Interview score of 14. The SW was alert and oriented but was delusional. S had exhibited some b behaviors might be du sister about 2 weeks	close the door because she lived with Resident #1. she was standing at the the incident happened and y of Resident #4. Nurse #1 Resident #4 was being liatric services for ehaviors and medications. It the staff members were r residents away from her PM, Resident #4 was was interviewed. She stated coming into her room and sident #4 then said "I shut because she didn't want AM, the PA was ed that she was informed of rred with Residents #1 and that she expected the bory care unit to be safe. AM, the Social Worker d. She stated that she was sing the resident's cognition ents. The SW indicated gnition was intact and she for Mental Status (BIMS) indicated that Resident #4 d to person, place and time She added that Resident #4 ehaviors lately and these ue to the passing of her	F	600			

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DEPART CENTER		FORM APPROVED OMB NO. 0938-0391					
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		345534	B. WING				C /28/2018
NAME OF PI	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	abusive to staff and o witnessed her telling o my room or else" tried to redirect other Resident #4's room. On 11/15 at 10:05 AW was observed in bed unit) with a sitter at be On 11/15/18 at 2:50 F interviewed. She staft following Resident #4 disorder with wanderi Resident #4 was a ple and she did not have she had pushed anott that she made change for the staff to continu further indicated that i unit were good on not approaches like redire playing music and off were agitated. On 11/16/18 at 10:24 interviewed. The DO expectation in the me the residents safe. The Administrator and were notified of the im 11/27/18 at 8:55 AM.	sident #4 could be verbally ther residents. She had other residents "get out of NA #3 indicated that she residents away from A and 1:30 PM, Resident #4 (outside the memory care edside. PM, the GNP was ted that she had been due to her delusional ng. The GNP indicated that easant, calm and sweet lady any behaviors until one day her resident. She stated es to her medications and te the monitoring. The GNP the staff in the memory care n- pharmacological ection, keeping them busy, ering snacks when they AM, the DON was N stated that her mory care unit was to keep d the Director of Nursing mediate jeopardy on	F	600			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROV OMB NO. 0938-03	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345534	B. WING				C / <b>28/2018</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					2702 FARRELL ROAD		
SANFORD	HEALTH & REHABILITA	ATION CO			SANFORD, NC 27330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	been affected by the of On 9-26-18, Resident checks. She was mo until 9/28/18 for 24 ho cursing at her roomm and hitting roommate roommate was moved Seroquel 50 mg by m 150mg by mouth at 7 Psychiatric PA. An or hours PRN for anxiety and Psychological Sy initiated if resident wa x 12 days. On 9-27-18 into a private room. Of argumentative with ar medications and refus medications. No noted behaviors u yelled at another resid of resident hand. The by staff and redirected for Haldol 0.5mg by m ordered due to increa resident yelling at a re On 10-9-18, at 2:00Pl chair and threw it at F proceeded to punch F she got up out of her Health Certified Nursi incident and Resident separated by the aide charge nurse from Re Resident # 3 on 1:1 u the hospital via facility	ve action will be se resident found to have deficient practice; #3 was put on Q 15 minute nitored by the charge nurse burs/7 days a week due to ate, attempting to hit staff, with call bell. At that time, d out of Resident #3 room, outh at 1pm and Seroquel PM were initiated by rder for Ativan 0.5 mg q 6 // agitation and Behavioral mptoms of Dementia was us up between 9pm and 2am 8, Resident #3 was moved Dn 9/28/18 resident was nother resident, spit out sed remainder of ntil 10-7-18, when resident dent and snatched a cup out residents were separated d. On 10-8-18, new orders nouth at bedtime was sing behaviors due to esident on 10-7-18. M Resident # 3, picked up a Resident # 2, then Resident #2 in her arm when chair to walk away. Home ng Assistant witnessed the	F	600			

Facility ID: 20050005

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/27/2018 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345534	B. WING			11	C / <b>28/2018</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SANFOR	HEALTH & REHABILIT			27	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 PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 600	on Resident # 2, and Police were called by both residents were in Neither resident was happened as both Bri Status scores are 0. If and Physician were in by the Unit Manager. by the Unit Manager of the memory care unit assessed. Psychiatric Physician during the time of the Psychiatric PA review medications and mad discontinuation of Ha every 6 hours as nee Seroquel 150mg daily 100mg at bedtime. Fi that no incidents sinc of Seroquel. The event occurred di place failed to preven behaviors. 100% skin assessme secured memory care Unit Managers on 10- identified. 100% Res Interviews were comp residents by the Socia Director of Nursing, M Maintenance Director Admissions, Business Nurse, Activities. No interviews. Example you feel the resident	noted a red mark on her leg. the DON at 2:20 PM and nerviewed by the officer. able to explain what ief Interview for Mental Both Responsible Person nade aware of the incident Skin checks were obtained on all residents residing in . No abuse was reported or Assistant was in house incident on 10-9-18. red Resident #3's le changes to include Idol, order for Ativan 0.5 mg ded, discontinuation of y at 1pm, start Seroquel Psychiatric PA noted in note e 9-26-18 and the increase use to interventions put in at Resident #3 from having nt of all residents in the e unit was completed by the -9-18 No concerns were ident Representative bleted for the locked unit al Worker, Unit Managers, Medical Records, r, Dietary Manager, s Office, Minimum Data Set concerns from voiced from of Interview Questions: Do been harmed by another ? If yes, was facility made	F	600			

Facility ID: 20050005

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 12/27/2018 DRM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) D.	ATE SURVEY OMPLETED
		345534	B. WING				C 11/28/2018
NAME OF P	ROVIDER OR SUPPLIER	•	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
SANFOR	D HEALTH & REHABILIT	ATION CO			702 FARRELL ROAD SANFORD, 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	A 100% all staff In-se 10-9-18 on abuse Pre Director of Nursing. prevention of residen signs and symptoms behavioral assessme monitoring and behav- include updating of pl was completed by 10 On 10-28-18, Reside immediately separate immediately separate immediately placed o knocking Resident # reassessed for Brief I and proper placemen Resident # 4 was mo memory care unit with decrease her agitatio updated to reflect cha immediately assesse and unable to bear w for Resident # 1. Res a hip fracture, and tra 10-28-18. 100% skin audit was manager and charge secured memory care concerns identified. Representative Intervi locked unit residents Managers, Director o Maintenance Director Admissions, Business Nurse, Activities. No interviews. Example you feel the resident	arvice was initiated on evention/Intervention by the The in service included t abuse, and recognizing of abuse, dementia protocol, int, intervention and vioral management to lan of care. The In service /11/18. Ints #1 and #4 were ed by staff. Resident #4 was in a 1:1 sitter secondary to 1 down. Resident #4 was interview for Mental Status it in the memory care unit. ved to a room out of the h a 1:1 sitter in an effort to n and her care plan was anges. Resident #1 was d and found to be in pain eight. XRAY was ordered sident # 1 was found to have ansported to the hospital on completed by the unit nurse on all residents in the e unit on 10-28-18, no 100% Resident views were completed for the by the Social Worker, Unit f Nursing, Medical Records, r, Dietary Manager, s Office, Minimum Data Set concerns from voiced from of Interview Questions: Do has been harmed by another ? If yes, was facility made	F	600			

Facility ID: 20050005

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345534	B. WING				C 28/2018
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
SANFORI	DHEALTH & 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	The event occurred a report increasing beh- the investigation. The complaint survey on 2 Resident #4 with incre towards others, thoug resident chart does no A 100% all staff In Se Director of Nursing or and neglect, signs an prevention of abuse, p problematic behavior and precipitating facto Address how the facil residents having the p the same deficient pra On 11/21/18 100% au and DON of all curren reviewed back to 8/01 interventions that wer behaviors. Changes as they were identified Address what measure systemic changes ma deficient practice will An in service on beha initiated on 11/24/18 to nursing staff to includ certified nursing assiss interventions and mor documentation of inter and reporting to the o	s staff did not document and aviors as reported during e staff interviewed during 11/14-11/16 reported easing verbal aggression th the documentation in the ot reflect any concerns. rvice was conducted by the in 10-28-18 to include abuse d symptoms of abuse and proper documentation of to include onset, frequency ors. ity will identify other botential to be affected by actice; udit by the unit managers at resident notes were 1/18 for effectiveness of e put in place regarding in plan of care were made d during the audit. re will be put into place or ide to ensure that the not recur; wor management was by the ADON to 100% all e all licensed nurses and itants to include	F	60			

Facility ID: 20050005

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JENTER	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY IPLETED
		345534	B. WING		11	C // <b>28/2018</b>
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
SANFORD	HEALTH & REHABILIT	ATION CO		702 FARRELL ROAD		
			§	SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT 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	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From pag	e 20	F 600			
	Indicate how the faci	lity plans to monitor its e sure that solutions are				
	sustained: and includ action will be comple	de dates when corrective ted;				
		heet audit tool, the Unit				
	Managers, RN Supervisors, ADON, and/or DON reviewed progress notes and 24 hour report sheets during M-F clinical meeting 5 x weekly x 12 weeks to identify reported behaviors of					
	residents that require intervention of services or changes in staffing ratio based on resident needs and behaviors. This will be reviewed daily by the DON, ADON, RN Supervisors, Unit Managers or Administrator. The results will be presented to the Quality Assurance Committee monthly x 3.					
	as evidenced by inte	on was verified on 11/28/18 rview of licensed and n-service training on abuse				
	policy and procedure abuse and abuse pre- interviewed and they an in-service on beha	e and signs and symptoms of evention. Nursing staff were verified that they received avior management,				
	behavior to the on-ca Unit Managers and th Nursing were intervie	havior and reporting of all nurse supervisor. The he Assistant Director of ewed and they verified that I on 11/21/18. The behavior				
	documentation flows	heet audit tool was reviewed progress notes and the 24				
F 725 SS=J	Sufficient Nursing St CFR(s): 483.35(a)(1)		F 725			12/12/18

Facility ID: 20050005

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		ND HUMAN SERVICES			PRINTED: 12/27/20 FORM APPROVI OMB NO. 0938-03		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345534	B. WING _		C 11/28/2018		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
SANEODD	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 C ( (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE COMPLETIO D THE APPROPRIATE DATE		
F 725	Continued From page	o 01		205			
1 725	1.3		F7	25			
	-	e sufficient nursing staff with					
		etencies and skills sets to related services to assure					
		ttain or maintain the highest					
		mental, and psychosocial					
		sident, as determined by					
		s and individual plans of care					
	and considering the r	number, acuity and					
		lity's resident population in					
	accordance with the facility assessment required						
	at §483.70(e).						
	§483.35(a)(1) The fac	cility must provide services					
	-	s of each of the following					
	• •	n a 24-hour basis to provide					
		sidents in accordance with					
	resident care plans:	ad under percerent (a) of					
	this section, licensed	ed under paragraph (e) of					
		sonnel, including but not					
	limited to nurse aides						
	§483.35(a)(2) Except	twhen weived under					
	• • • • •	section, the facility must					
		nurse to serve as a charge					
	nurse on each tour of	-					
		is not met as evidenced					
	by:						
		iew, observation and staff		On 10-9-18 and 10-28-18			
	-	failed to provide sufficient		and Resident #4, showed			
	•	ct residents from physical		towards other residents.			
		pled residents reviewed for		were placed on 1:1 for co			
		& #4). Resident #3 had with a call bell on 9/26/18 and		monitoring of behaviors a others. Based on intervie			
		n Resident #2 and had		non alert and oriented, st			
		shoulder on 10/9/18 causing		assessments, no other re			
	•	nt #2's leg. Resident #4 had		increased monitoring nee			
	-	with a walker causing		increased staffing.			
	•	id sustained a left hip		On 10-9-18 the incident w	vas not		

Facility ID: 20050005

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/27/20 FORM APPROVE OMB NO. 0938-039
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345534	B. WING		C 11/28/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
				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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 725	Continued From page	<u>-</u> 22	F 72	5	
	fracture on 10/28/18.		172		
				witnessed by facility staff. The 10-28-18 incident was	s witness by a
	Immediate ieonardy l	began on 9/26/18 when the		staff member, but the staff	-
		sufficient nursing staff to		unable to intervene timely.	
		t Residents # 9 and #2 from		was standing at her cart a	nd saw resident
	abuse by Resident #	3. Resident #3 had beaten		#1 walking down the hall a	approximately 75
	Resident #9 with a ca	all bell on 9/26/18 and had		to 100 feet from her. She	then saw
		unched Resident #2 causing		resident #4 push her walke	
		on 10/9/18. The facility also		#1 causing resident #1 to	
		nt nursing staff to monitor		On 10-7-18, Resident #3 s	
	and to protect Reside	-		aggressive behaviors towa	
		ng Resident #1 with a walker to fall and to fracture her hip		On 10-8-18, Haldol every	•
		iate jeopardy was removed		needed was ordered. On	
	on 11/28/18 when the			Resident #3 and Resident	-
		Illegations. The facility		separated after resident #	
	-	iance at a lower scope and		at resident #2 and then hit	
	-	n with potential for more		stood from her chair to wa	lk away.
	than minimal harm th	at is not immediate		Resident #3 was placed or	n a 1:1.
	jeopardy) to ensure n	nonitoring systems put into		Resident #3 was seen by	the Psychiatric
	place are effective.			PA on 10-9-18, with medic	5
				On 10-10-18, Resident #3	
	Findings included:			increased aggressive beha	
	This tax is succeed up	formed to .		and residents, and was dis	-
	This tag is crossed re			hospital for evaluation and Resident #2 was assessed	
	F 600 - Rased on rec	ord review, observation and		pain and was taken to acti	
		tant (PA) and Geriatric		On 10-28-18, Resident #4	
		NP) interview, the facility		a 1:1 sitter secondary to k	-
		itively impaired residents		Resident # 1 down. Resid	
		for 2 of 3 sampled residents		immediately separated, to	
	reviewed for abuse (I	Residents #3 & #4).		Resident #4 on 1:1 sitter.	
		s cognitively impaired and		was transported to the hos	spital secondary
		sive behaviors towards other		to a hip fracture.	
		n Resident #9 (who was		On 10-28-18, a 100% staf	
		with a call bell on 9/26/18		provided by the Director of	
		air on Resident #2 (who was		include Abuse and preven	
		and had punched her on the		signs and symptoms of ab	
	shoulder on 10/9/18	causing a red spot on		documentation and reporti	ing or

Facility ID: 20050005

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/27 FORM APPRO OMB NO. 0938-	OVE
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345534	B. WING		C 11/28/2018	8
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
			:	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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE COMPLE	ETIO
F 725	Continued From page	e 23	F 725	5		
F 725	other residents pushe cognitively impaired) Resident #1 to fall an fracture on 10/28/18. An interview with Nur 11/14/18 at 11:46 AW stated that she had w care unit. She indicat constant monitoring e Resident #3 was very verbally abusive to st needed constant redi verbally abusive and her room or near her needed to be redirect Nurse #2 stated that not enough to take ca to monitor the resident that when the 2 NAs providing care and sh there were no staff m an eye on these resident An interview with NA 11/14/18 at 12:05 PW worked in the memor the residents in the u needed to be redirect behaviors were unpre- other residents. NA st	esident #4 who was was verbally abusive to ed Resident # 1 (who was with a walker causing id sustained a left hip rse #1 was conducted on and at 3:15 PM. Nurse #1 yorked 7A-7P in the memory red that the residents needed especially Resident #3. y combative, physically and aff and residents and she rection. Resident #4 was she didn't want anybody in room so other residents ted away from her room. two Nurse Aides (NAs) were are of resident's needs and nts in the unit. She indicated were in the resident's rooms ne was passing medications, nembers on the hall to keep dents. #2 was conducted on 1. NA #2 stated that she y care unit. She stated that nit had behaviors and they ted. She indicated that their edictable and they could hurt #2 stated that two NAs on ugh to monitor the residents	F 725	problematic behavior to include of frequency and precipitating factor was completed on 10/31/18. An in service was initiated on 11 the Director of Nursing, and complete 11/26/18 to include monitoring of and behavioral interventions to a licensed nurses by the Director of and the Assistant Director of Nur The in service also covered notifi the on call nurse immediately for behaviors that show signs of agg harm to others or harm to self to accommodate for resident needs staffing changes. On 11-21-18 an audit was conduc the Unit Managers to evaluate ref for behaviors that require addition services or change of staffing ne accommodate the residents. Th was conducted on progress note hour reports dating back to Augu 2018 to present. Based on the evaluations, one resident was id having an increased need, and r was put on Q15 mins behavior c Based on the resident needs and behaviors, resident monitoring b be adjusted accordingly in order provide adequate supervision to changing needs of the resident to The QA process began on 11-21 utilizing the review of progress n verbal report in the M-F clinical r and from the on call nurse to ass	-24-18 by Assistant eed on f behavior all of Nursing rsing. fication of r resident gression, s and ucted by esidents anal eed to e audit es and 24 ust 1, entified as resident hecks, d y staff will to the behaviors. I-18 by otes and neeting	
	11/14/18 at 1:16 PM.	#1 was conducted on NA #1 stated that she had		determining residents that may r increased monitoring by staff. T	need he DON,	
	worked in the memor	y care unit. She stated that		ADON, RN Supervisors, Wound	Nurse or	

Facility ID: 20050005

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STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED C         NAME OF PROVIDER OR SUPPLIER       345534       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       11/28/2018         SANFORD HEALTH & REHABILITATION CO       STREET ADDRESS, CITY, STATE, ZIP CODE       2702 FARRELL ROAD SANFORD, NC 27330         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       (X5)			ID HUMAN SERVICES MEDICAID SERVICES			FC	TED: 12/27/2018 DRM APPROVEI NO. 0938-039	
34534         B. WHO         11/28/2018           SINCECE ADDRESS         SIN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION						(X3) DATE SURVEY	
NAME OF PROVIDER OF SUPPLIER       STREET ADDRESS. CITY. STATE JIP CODE         SANFORD, NC 27330       SUMMARY STATEMENT OF DEFICIENCES IN CACH DEFICIENCES IN CACH DEFICIENCY MUST REFREENDED WILL THE RECOLL TO PROVIDER'S PLAN OF CORRECTION ECOND DEFICIENCES IN CACH DEFICIENCY MUST REFREENDED WILL DEFICIENCES IN CACH DEFICIENCY MUST REFREENDED WILL DEFICIENCES IN CACH DEFICIENCY MUST REFREENDED FOR LUL PROVIDER'S PLAN OF CORRECTION ECOND DEFICIENCES IN CACH DEFICIENCY MUST REFREENDED FOR LUL PROVIDER'S PLAN OF CORRECTION ECOND DEFICIENCES IN CACH DEFICIENCY MUST REFREENDED FOR LUL PROVIDER'S PLAN OF CORRECTION ECOND DEFICIENCES IN CACH DEFICIENCY MUST REFREENDED FOR LUL PROVIDER'S PLAN OF CORRECTION ECOND DEFICIENCY IN THE APPROPRIATE DEFICIENCE OF APPROPRIATE DEFICIENCE OF APPROPRIATE DEFICIENCE OF APROPRIATE DEFICIENC			345534	B. WING			-	
SAMFORD, HEALTH & REHABILITATION CO         SAMFORD, NC 27330           (Mai) D PRETX TAS         SUMMARY SIATEMENT OF DEFICIENCIES (EACH DEFICIENCY UNIS BE PRECED BY FILL REGULATIONY ON LSC IDENTIFYME INFORMATION)         D PRETX RESCLATIONY ON LSC IDENTIFYME INFORMATION SUBJECT         F 725           F 725         Unit Managers will use the behaviors dher residents N the bar other halt the facility was shord of staff especially nurse alses. At times, there were three NAS assigned but when another NA had called out in the other halt the PAS in the unit was very hard. She tried her best to provide the care but she dignt have the time to monitor the residents. An interview with Mass Bas general and the behaviors. She would like three NAS assigned at all times but that varies depending on the residents and the phalting more NAS. The DON stated that her expectation in the memory care unit was low keep the residents assign. An interview with Nurse #3 was conducte	NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CC		11120/2010	
EARFORD, NC 27330           PREFX TAG         SUMMARY STATEMENT OF DEFICIENCIES (PECH DEFICIENCY MUST BE PRECEDED BY PULL RECULTORY OR LSC DENTIFYING INFORMATION)         D PREFX TAG         PREFX (PECH DEFICIENCY MUST BE PRECEDED BY PULL RECULTORY OR LSC DENTIFYING INFORMATION)         D PREFX TAG         PREFX (PECH CORRECTION (PECK CORRECTION (PECK CORRECTION CONSECTION (PECK CORRECTION CORRECTION (PECK CORRECTION CONSECTION (PECK CORRECTION CONSECTION CONSECTION CONSECTION CONSECTION CONSECTION (PECK CORRECTION CONSECTION CONSECTION CONSECTION CONSECTION CONSECTION CONSECTION CONSECTION CONSECTION CONSECTION CONSECTION (PECK CORRECTION CONSECTION CONSECTI					2702 FARRELL ROAD			
PREFIX TAO         IEACH DEPICIENCY MUST BE PRECEDED BY FULL REGULTIORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED to 11 HA PROPORTATE         COMMETTION DEFICENCY           F 725         Continued From page 24 Resident #3 Was very combative, mean and hateful. She needed to be redirected all the time away from other residents. NA #1 indicated that Resident #4 didn't want anybody on her space so other residents hat to be redirected all the times, there were three NAs assigned but when another NA had called out in the other hall, the NA in the unit was we hard. She tried her besit to provide the care but she didn't have the time to monitor the residents. She trid her besits to provide the care but she didn't have the time to monitor the residents. The DON stated that the facility was short of 11/16/16 at 10:24 AM. The DON stated that she assigned at all times but that varies depending on the resident's needs. The DON also reported that the facility was short of NAs especially on the second shift and they had the him memory care unit was to keep the residents safe. An interview with Nurse #3 stated that she had worked in the memory care unit. She indicated that residents and to keep an eye on them. She added that the unit was short staff and was really bad couple of months now. On 11/127/18 at 4:35 PM, the memory care unit         F 725	SANFORD	HEALTH & REHABILIT	ATION CO		SANFORD, NC 27330			
Resident #3 was very combative, mean and hateful. She needed to be redirected all the time away from other residents. NA#1 indicated that Resident #4 didn't want anybody on her space so other residents had to be redirected away from her room. NA#1 reported that the facility was short of staff especially nurse aides. At times, there were three NAs assigned but when another NA had called out in the other hall, the NA in the unit was the first one they had to pull out leaving the unit with just two NAs. With two NAs in the unit was very hard. She tried her best to provide the care but she didn't have the time to monitor the residents.       Unit Managers will use the behavior staffing monitoring tool to document residents multiply to ensure interventions are appropriate and effective weekly x 12 weeks beginning the results of the audits to the Quality Assurance Committee Meeting Monthly x 3. This in service will be added to the new nurse hire orientation.         An interview with the Director of Nursing (DON) was conducted on 111/01/8 at 10:24 AM. The DON stated that he assigned at all times but that varies depending on the resident's needs. The DON also reported that the facility was short of NAs especially on the second shift and they had fried hing more NAs. The DON stated that residents in the unit had behaviors that needed to be monitored. She indicated that with hwo NAs assigned in the unit was to keep an eye on them. She added that the unit was not staff and was really bad couple of months now.         On 11/27/18 at 4:35 PM, the memory care unit	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ON SHOULD BE IE APPROPRIATE	COMPLETION	
	F 725	Resident #3 was very hateful. She needed away from other reside Resident #4 didn't was other residents had to her room. NA #1 rep short of staff especial there were three NAss NA had called out in fu unit was the first one the unit with just two unit was very hard. S the care but she didn the residents. An interview with the was conducted on 11 DON stated that she unit depending on the behaviors. She would all times but that varia resident's needs. The facility was short of N shift and they had trie DON stated that here care unit was to keep An interview with Nur 11/27/18 at 4:30 PM. had worked in the me indicated that resident that needed to be mo with two NAs assigned to take care of the resion them. She added and was really bad co	<ul> <li>v combative, mean and to be redirected all the time dents. NA #1 indicated that int anybody on her space so to be redirected away from orted that the facility was ly nurse aides. At times, assigned but when another the other hall, the NA in the they had to pull out leaving NAs. With two NAs in the he tried her best to provide 't have the time to monitor</li> <li>Director of Nursing (DON) /16/18 at 10:24 AM. The assigned nursing staff in the eresident's needs and the d like three NAs assigned at the eresident's needs and the d like three NAs assigned at the eresident's needs and the d like three NAs assigned at the sepecially on the second ed hiring more NAs. The expectation in the memory of the residents safe.</li> <li>se #3 was conducted on Nurse #3 stated that she emory care unit. She indicated that ed in the hall was not enough sidents and to keep an eye that the unit was short staff ouple of months now.</li> </ul>	F 7:	Unit Managers will use the b staffing monitoring tool to do residents with behaviors. Th will review the results of the documentation weekly to en interventions are appropriate weekly x 12 weeks beginnin The Director of Nursing will results of the audits to the Q Assurance Committee Meet 3. This in service will be add	ocument behaviors sure and effective g 11/21/18. bring the quality ing Monthly x		

Facility ID: 20050005

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED		
		345534	B. WING			C 11/28/2018		
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
SANFORD	HEALTH & REHABILITA	ATION CO			2702 FARRELL ROAD SANFORD, NC 27330			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 725	the hall. When intervie one NA was giving a s was taking a resident that the third NA was hall but she was told to replace. The Unit M Worker were observe their offices. An interview with NA s 11/28/18 at 8:50 AM. worked in the memory at times she was aske staff. NA #5 indicated was rough, a lot of resi they needed to be mo were in the resident ' on the hall to monitor An interview with Sch conducted on 11/28/1 #1 stated that she trie the unit depending on that the facility was sh trying to hire more NA not stay. When there call other NAs to com other NAs to stay ove the facility had staffing hire more staff especies The Administrator and were notified of the im 11/27/18 at 8:55 AM.	ewed, Nurse #3 stated that shower and the other NA to smoke. She also stated pulled to work on the other that another NA was coming Manager and the Social d in the unit but they were in #5 was conducted on She stated that she had y care unit. She stated that ed to stay over due to short d that two NAs in the unit sidents with behaviors and onitored. If the two NAs s room, there were no NA the residents. eduler #1 and #2 was 8 at 10:05 AM. Scheduler ed to schedule 2-3 NAs in the census. She stated nort of NAs and they were as but most of them would were call outs, she tried to e in or she would request r. Scheduler #2 stated that g issues but they had tried to ally NAs. PM, the facility provided the	F	725	5			

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	M APPROVED D. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
							C / <b>28/2018</b>	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	_ <u>.</u>		
SANFOR	HEALTH & REHABILIT	ATION CO			2702 FARRELL ROAD			
	1			3	SANFORD, NC 27330			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 725	Address how correctinac complished for those been affected by the operation of the second sec	ve action will be se residents found to have deficient practice; 8-18, Resident #3 and behaviors towards other ents were placed on 1:1 for oring of behaviors and Based on interviews of RP ' iented, staff and skin er residents had an need to adjust for increased ent was not witnessed by t was witness by a staff member was unable to e nurse was standing at her #1 walking down the hall 00 feet from her. She then her walker into resident #1 of fall. #3 showed aggressive other resident and residents 10-8-18, Haldol every 6 a ordered. On 10/9/18, ident #2 were separated wa chair at resident #2 and he stood from her chair to #3 was placed on a 1:1. In by the Psychiatric PA on tion changes. On 10-10-18, increased aggressive I residents, and was spital for evaluation and #2 was assessed and	F	725				

Facility ID: 20050005

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345534	B. WING			C 11/28/2018	
NAME OF P	ROVIDER OR SUPPLIER	1			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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 725	Residents were immer placing Resident #4 of was transported to the fracture. Address how the facil residents having the p the same deficient pra- On 11-21-18 an audit Managers to evaluate require additional ser need to accommodate was conducted on pro- reports dating back to Based on the evaluate identified as having a resident was put on O Address what measur systemic changes ma- deficient practice will On 10-28-18, a 100% provided by the Direc Abuse and prevention symptoms of abuse, p reporting of problema onset, frequency and was completed on 10 An in service was initi Director of Nursing ar Nursing, and complet monitoring of behavio interventions to all lice of Nursing and the As The in service also co- call nurse immediated	ediately separated, to include on 1:1 sitter. Resident #1 e hospital secondary to a hip lity will identify other botential to be affected by actice; was conducted by the Unit e residents for behaviors that vices or change of staffing e the residents. The audit ogress notes and 24 hour o August 1, 2018 to present. ions, one resident was n increased need, and 215 mins behavior checks, res will be put into place or ade to ensure that the not recur; o staff in service was tor of Nursing to include n of abuse, signs and proper documentation and tic behavior to include precipitating factors. This /31/18. iated on 11-24-18 by the nd the Assistant Director of ed on 11/26/18 to include	F	72	5		

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	S FOR MEDICARE &			CONSTRUCTION		IO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>、</b> ,		· · ·	TE SURVEY MPLETED
						С
		345534	B. WING		1	1/28/2018
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SANFOR	) HEALTH & REHABILIT	ATION CO		702 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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 725	to self to accommoda staffing changes. Indicate how the facil performance to make sustained; and Includ action will be comple Based on the residen resident monitoring b accordingly in order t supervision to the cha- behaviors. The QA pr utilizing the review of report in the M-F clini call nurse to assist in that may need increa DON, ADON, RN Su Unit Managers will us monitoring tool to doo behaviors. The QA te the behaviors docum interventions are app	ate for resident needs and ity plans to monitor its e sure that solutions are le dates when corrective ted. It needs and behaviors, y staff will be adjusted	F 725			
	Quality Assurance Co	results of the audits to the ommittee Meeting Monthly x I be added to the new nurse				
	as evidenced by inter unlicensed staff on in policy and procedure abuse and abuse pre interviewed and they an in-service on beha documentation of beh	-service training on abuse and signs and symptoms of evention. Nursing staff were verified that they received avior management, navior and reporting of Il nurse supervisor. The				

Facility ID: 20050005

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		ID HUMAN SERVICES				FOR	M APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTI	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345534	B. WING			C 11/28/2018	
NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO				2702 FAR	NDRESS, CITY, STATE, ZIP CODE RELL ROAD RD, NC 27330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 725	the audit was started documentation flowsh behavior staffing mon	wed and they verified that on 11/21/18. The behavior neet audit tool and the itoring tool were reviewed rogress notes and the 24	F	725			

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