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			Term Memory OK.				u		
LOU // U// M ALX: 3M AW/ THE SOCIAL WORKER			On 7/10/10 -+ 0.00 A	M the Casial Marker					
revealed she was responsible for completing proceeding.									

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.

07/26/2019

		ND HUMAN SERVICES MEDICAID SERVICES			FC	TED: 08/08/2019 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	PLE CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		345313	B. WING			07/10/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
		REHABILITATION CENTER		HWY 305 NORTH		
NORTHAN	IF I ON NORSING AND R			JACKSON, NC 27845		
(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	(X5) COMPLETION DATE
F 641	was off the week Res the facility. In an interview on 7/1 Nurse stated Resider and had a BIMS of 13 completed the MDS a not get done. The M future when the social or the Activity Directo the BIMS interview. In an interview on 7/1 Administrator stated in	on the MDS. She stated she sident #11 was admitted to 10/19 at 8:45 AM, the MDS ht #11 was alert and oriented 3. She stated she had and the BIMs interview did DS Nurse stated that in the al worker was off, either she or would need to complete 10/19 at 8:47 AM the if the Social Worker was out MDS Nurse would complete	F 64		most current essments ed by the insure the re udit was cumented on re were no d on 7/25/19 rker (SW) ant MDS ne Resident manual with essments coded attern (2) sciplinary r nsibility of at section of nurses and	
				in-service during orientation by 10% of all current residents co MDS assessments will be revi DON to ensure completion of a accurate coding of the MDS assessments, including cognit	mpleted ewed by the and for	

Event ID: NGJ611

Facility ID: 923228

If continuation sheet Page 2 of 14

		ND HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 08/08/201 RM APPROVEI O. 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345313	B. WING		07	7/10/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHAN	MPTON NURSING AND F	REHABILITATION CENTER		IWY 305 NORTH IACKSON, NC 27845		
	STIMMADA ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORR	ECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE
F 641 F 657 SS=D	CFR(s): 483.21(b)(2) §483.21(b) Compreh §483.21(b)(2) A com be- (i) Developed within the comprehensive a (ii) Prepared by an in includes but is not lin (A) The attending phy (B) A registered nurs resident.	d Revision (i)-(iii) ensive Care Plans prehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that hited to	F 641	utilizing an MDS Accuracy QI To for 8 weeks then monthly X 1 m identified areas of concern will b immediately addressed by the D include additional training to the nurse or SW and modifications is assessment as indicated. The Administrator will review and ini MDS Accuracy QI Tool weekly for and then monthly X 1 month for and to ensure all areas of concer been addressed. The Administrator will forward th of the MDS Accuracy QI Tool to Executive QA Committee month months. The Executive QA Com meet monthly x 3 months to rev MDS Accuracy QI Tool to detern trends and/or issues that may n further interventions put into pla determine the need for further a frequency of monitoring.	onth. Any be DON to MDS to tial the br 8 weeks accuracy erns have he results the ly X 3 mittee will iew the nine eed ce and to	8/7/19

Event ID: NGJ611

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 08/08/20 FORM APPROV OMB NO. 0938-03
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345313	B. WING			07/10/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, C	ITY, STATE, ZIP CODE	
NORTHAI	MPTON NURSING AND R	EHABILITATION CENTER		HWY 305 NORTH JACKSON, NC 27	845	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIC
F 657	 (E) To the extent pract the resident and the resident and their resident must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and ca assessments. This REQUIREMENT by: Based on record rev facility failed to updat services for contractures idents (Resident # positioning/range of rev The findings included Resident #20 was ad 6/1/2018 with diagnost An Occupational The discharge summary re included an analysis read in part: Gains in (PROM) and splinting contracture risk. An and resident now tole education and trainin 	and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident aresentative is determined a development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the quarterly review T is not met as evidenced iew and staff interviews, the e the care plan with splinting are management for 1 of 3 20) reviewed for notion. I: mitted to the facility on ses to include dementia. rapy (OT) progress and note dated 9/11/2018, of Functional Outcome that passive range of motion g tolerance have decreased H flex splint was ordered, erates 4 to 6 hours. Nursing g provided for splinting es of donned splint on	F	and revised of Data Set (MD Director of Nu splinting servi management. A 100% audit initiated on 7/2 Nursing (DON residents #20 services to en care plan refle needs. Any ca concern will b by 8/5/19 with of Nursing, to residents.	Care Plan was reviewe n 7/22/19 by the Minimu S) nurse with oversite b ursing (DON) to reflect ices for contracture of all care plans was 22/19 by the Director of J), including care plans to and residents with splin issure that all areas of th ect the resident's individ are plan with areas of the updated by the MDS in oversight from the Director reflect the splinting need will be completed by 8/7	um by the f for nting le lual nurse ector eds of

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				MAPPROVE 2. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMF	SURVEY PLETED
		345313	B. WING		07/	/10/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
				HWY 305 NORTH		
NORTHAI	MPTON NURSING AND F	REHABILITATION CENTER		JACKSON, NC 27845		
(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 AI CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIC DATE
F 657	Continued From page	e 4	F 65	7		
F 03/	A signed Physician o OT services complete Maintenance Prograr right wrist splint. Her annual Minimum (MDS) dated 5/20/20 be severely impaired assistance from staff (ADL), and had funct motion for bilateral up lower extremities. Her care plan last rev a focus of assistance contractures, with a g extremity contracture as follows: 1) Depend chair). 2) functional r cushion to be placed side or between as n The care plan did not interventions for the u The care guide portic address a splint to th On 7/9/2019 at 11:46 conducted with Reha who stated Resident extension splint for 6 of 2018. The Rehab	rder dated 9/11/2018 read: ed. FMP (Functional m) established regarding Data Set Assessment 19 revealed her cognition to . She required total for activities of daily living ional limitation in range of oper extremities and bilateral vised on 5/24/2019 included for mobility related to goal of no worsening of lower es. The interventions were dent in Gerichair (reclining maintenance plan: wedge under knees and pillows on eeded for pressure relief. t address a focus or upper extremity contracture. on of the care plan did not	F 65	7 by the MDS Consultant a interdisciplinary care plar and hall nurses: Minimun (MDS)nurse, Dietary Mar Social Worker (SW), Staf Quality Improvement nurs Director and 100% of the requirements for complet comprehensive care plan resident and to review an plan for each resident char splinting services to inclu resident #20 weekly X 8 monthly X 1 month by the Nursing to ensure that the accurately reflects the resident the Splinting QI Audit Too interdisciplinary care plar or hall nurses will be retra care plan will be revised i the DON for any identified concern. The Administra and initial the Splinting Q weekly X 8 weeks then month for compliance and areas of concern have be The DON will present the Splinting QI Audit Tool to	a team members in Data Set hager (DM), if Facilitator, se, Activities in unuses on the ing in for each and revise the care ange as needed. If of 10% of all requires de care plans for weeks then e Director of e care plans sidents utilizing ol. The in team members ained and the immediately by d areas of tor will review I Audit Tool honthly X 1 d to ensure all een addressed. e findings of the	
	and the placement of	scharged from OT services f the splint was turned over		Quality Assurance (QA) of monthly for 3 months. Th Committee will meet mon	committee ne Executive QA	
	conducted with the O	PM, an interview was Decupational Therapist who he hand splint for Resident		and review the Splinting of determine trends and/or in need further interventions and to determine the nee	QI Audit Tool to issues that may s put into place	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		CONSTRUCTION	(X3) DATE	D. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· /			· /	PLETED
		345313	B. WING _			07	/10/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NORTHAN	IPTON NURSING AND R	EHABILITATION CENTER			VY 305 NORTH ICKSON, NC 27845		
(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 SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 657	Continued From page	- 5	F 6	57			
	#20 in 9/2018 and wr maintenance program The Occupational The staff on the use of the pictures of the splint a The Rehab Manager stated she was unabl the in-service and did been in-serviced. Th then stated she was r been done, but the pi probably have been t Occupational Therap Resident #20 for a wi staff were putting the	ote a functional n (FMP) for use of the splint. erapist stated she trained e splint and put up the as a visual reminder for staff. joined the interview and le to find documentation on a not know who would have e Occupational Therapist not sure if an in-service had ictures in the room would he in-service. The ist stated she had not seen hile, and she did not know if splint on her wrist as she would've expected staff to			frequency of monitoring.		
	oversaw the restorati therapy staff sent corr electronic medical rec plans when a residen therapy and was to b She stated she had n communication from splint for Resident #2 stated the only time s a hand splint was wh OT care, and stated s for the hand splint. T did not know of a Phy and was not aware of	IDS nurse who stated she ve program. She stated the nmunication via the cord (EMR) for restorative it was discharged from e followed by restorative.					

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	S FOR MEDICARE &			CONSTRUCTION	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345313	B. WING		07/10/2019
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
NORTHAI	MPTON NURSING AND R	EHABILITATION CENTER		IWY 305 NORTH ACKSON, NC 27845	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIO
F 657	Continued From page her.	9 6	F 657		
F 658 SS=D	who stated she expect between therapy staff wrist splint care would the care plan updated for providing	rector of Nursing (DON) eted better communication and the MDS nurse, so the d have been carried out and the care. eet Professional Standards	F 658		8/7/19
	as outlined by the cor must- (i) Meet professional a This REQUIREMENT by: Based on observatio interviews the facility order to provide splint management for 1 of reviewed for positioni The findings included Resident #20 was add 6/1/2018 with diagnos An Occupational The discharge summary m included an analysis of read in part: Gains in (PROM) and splinting contracture risk. An H	d or arranged by the facility, mprehensive care plan, standards of quality. is not met as evidenced ns, record review and staff failed to follow a Physician ting service for contracture 3 residents (Resident #20) ng/range of motion. : mitted to the facility on sis to include dementia. rapy (OT) progress and		F 658 Resident #20 was referred to therapy 7/9/19 by the Minimum Data Set (MDS nurse for contracture management. A clarification order was written on 7/22/ by the treatment nurse to discontinue splint until therapy evaluation. The pictures of the splinted hand/wrist in resident #20 room was removed on 7/ by the Director of Nursing (DON). A 100% of all residents to include resid #20 physician orders from 9/11/18 to 7/22/19 will be reviewed by 8/7/19 by f Director of Nursing and Medical Recon This audit is to identify residents with orders for splinting. All residents identi	5) 19 the 9/19 dent the ds.

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						<u>D. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		345313	B. WING		07	/10/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZI	P CODE	
NORTHAN	IPTON NURSING AND R	EHABILITATION CENTER		HWY 305 NORTH JACKSON, NC 27845		
(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 A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 658	Continued From page	e 7	F 65	58		
	management. Picture display for visual aid	es of donned splint on		by the Quality Improvem 8/7/19 to ensure the spli to the resident per the pl	nts were provided	
	"OT services complet Maintenance Program	n) established regarding		Therapy referrals and or were completed by the I identified areas of conce	DON for any	
	right wrist splint". The signature of the nurse	e order did not include a e receiving the order.		audit. An in-service will be com	npleted by 8/7/19	
	Resident #20's cognit	ated 5/20/2019 revealed tion to be severely impaired.		by the Director of Nursin 100% of all nursing assis include NA #1, restorativ	stants (NA) to ve aides,	
		g (ADL), and had functional motion for bilateral upper		medication aides and nu Nurse #1 regarding ensu provided splints per phys resident care guide. All r nursing assistants, resto	uring residents are sician's order and newly hired	
	a focus of assistance contractures, with a g	rised on 5/24/2019 included for mobility related to loal of no worsening of lower s. The interventions were		medication aides, and nu the in-service during orie Staff Facilitator.	urses will receive	
	as follows: 1) Depend chair). 2) functional r cushion to be placed	lent in Gerichair (reclining naintenance plan: wedge under knees and pillows on		An audit will be complete physician's orders for re- require splint services ar	sidents that nd observations of	
	The care plan did not interventions for the u	eeded for pressure relief. address a focus or have upper extremity contracture. n of the care plan did not		the resident to include re ensure the splint is being order. This audit will be X 8 weeks then monthly	g provided per completed weekly	
	address a splint to the Review of the July 20	e right hand.		Quality Improvement nu Splinting Audit Tool. The and/or nurse will be retra	rse utilizing the QI nursing assistant	
		d/Treatment Administration Resident #20 revealed no e right hand.		splint will be immediately the audit by the Quality I nurse for any identified a	Improvement areas of concern.	
	conducted of Resider	AM an observation was at #20 as she lay in her bed		The Director of Nursing V initial the QI Splinting Au 8 weeks then monthly X	idit Tool weekly X 1 month for	
		t hand was visible on top of inting device to her hand or		compliance and to ensui concern have been addr		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
	CONTRACTION		A. BUILDIN	3		
		345313	B. WING			/10/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
NORTHAN	IPTON NURSING AND R	EHABILITATION CENTER		HWY 305 NORTH JACKSON, NC 27845		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 658	Continued From page	28	F 6	58		
	that covered the hand above her bed. On 7/8/2019 at 12:09 conducted of Resider in her room. Her righ the sheet, with no spl wrist. The two large p hand/wrist remained the On 7/8/2019 at 3:35 F conducted of Resider in her room. Her righ the sheet, with no spl wrist. The two large p wrist/hand remained the On 7/9/2019 at 9:22 A conducted of Resider in her room. Her righ the sheet, with no spl the sheet, with no spl	AM an observation was thand was visible on top of inting device to her hand or pictures of a splinted taped above her bed. AM an observation was th #20 as she lay in her bed t hand was visible on top of inting device to her hand or ures of a splinted wrist/hand		The DON will present the fin QI Splinting Audit Tool to the Quality Assurance (QA) com monthly for 3 months. The I Committee will meet monthly and review the QI Splinting A determine trends and/or issu need further interventions pu and to determine the need for frequency of monitoring.	Executive mittee Executive QA y for 3 months Audit Tool to ues that may ut into place	
	conducted of daily mo Resident #20 with nu NA stated Resident # confused and very co extremities. The NA boots for her feet and under and between h	AM an observation was orning care provided to rsing assistant (NA) #1. The 20 was alert at times but ontracted with her stated Resident #20 had was positioned with pillows er knees. The NA stated thing about a splint for the				

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		ND HUMAN SERVICES MEDICAID SERVICES				F	VTED: 08/08/201 ORM APPROVE NO: 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) I	DATE SURVEY
		345313	B. WING				07/10/2019
NAME OF PF	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHAN	IPTON NURSING AND R	REHABILITATION CENTER			IWY 305 NORTH		
				J	ACKSON, NC 27845		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	Continued From page	_ Q	É E	658			
		t hand was visible on top of		000			
		linting device to her hand or					
	-	es of a splinted hand/wrist					
	remained taped abov	re her bed.					
	On 7/9/2019 at 2:48 I	PM an interview was					
		ledication Aid (MA) #1 who					
		had a splint to her hand, but					
	it was a long time ago						
		g ago it was. The MA stated					
		RA) would have been putting g the time it was on under					
	the restorative progra	-					
	conducted with Nurse #20 was under the Re splints and positionin NA would be expected positioning during the did not know why OT splints as she did not therapy had not inform splinting needed.	e day. The nurse stated she would give Resident #20 like to wear them, and med staff of any continued					
	conducted with Reha who stated Resident extension splint for 6	AM an interview was bilitation (Rehab) Manager #20 tolerated a right wrist hours per day in September					
	wrist splint was order	Manager stated the right red for continued use after scharged from OT services					
		the splint was turned over					
		ccupational Therapist who he hand splint for Resident					

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			0/0			10.0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	FE SURVEY MPLETED
		345313	B. WING		0	7/10/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHAN	IPTON NURSING AND F	REHABILITATION CENTER		HWY 305 NORTH JACKSON, NC 27845		
(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) COMPLETIO DATE
F 658	Continued From page	e 10	F 65	3		
	maintenance prograr	n (FMP) for use of the splint.				
		erapist stated she trained				
		e splint and put up the				
		as a visual reminder for staff.				
		joined the interview and le to find documentation on				
		a not know who would have				
		e Occupational Therapist				
		not sure if an in-service had				
	been done, but the p	ictures in the room would				
		the in-service. The OT				
		een Resident #20 for a while,				
		if staff was putting the splint				
		ad advised, but she would've the splint on for 4 to 6 hours				
	per day.					
		PM, an interview was				
		estorative Aide (RA) #1 who				
		was not on the restorative ot remember if she had ever				
	1 0	ve program. The RA stated				
		but a splint to the right wrist.				
		PM, an interview was				
		IDS nurse who stated she				
	therapy staff sent cor	ve program. She stated the				
		cord (EMR) for restorative				
		it was discharged from				
	therapy and was to b	e followed by restorative.				
	She stated she had r					
		OT via the EMR regarding a				
	-	0's hand. The MDS nurse				
	-	she knew Resident #20 had ile she was actively receiving				
		he did not know of any FMP				
		She further stated she did not				
	know of a Physician		1	1		1

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) D.	ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING) ´cc	OMPLETED
		345313	B. WING			07/10/2019
NAME OF P	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP COD	DE	
NORTHAN	IPTON NURSING AND R	REHABILITATION CENTER		1Y 305 NORTH CKSON, NC 27845		
(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) COMPLETIO DATE
F 658	Continued From page	e 11	F 658			
	not aware of the pictures of the splint above the resident's bed.					
F 812 SS=E	who stated usually the therapy and carried of DON stated RAs were care for the FMP. The remember of an in-set splint for Resident #2 FMP ever initiated for stated she did not know signed and transcribe when the Physician he further stated she exp communicate with state were already establis follow orders for care change of therapy. Food Procurement, St	irector of Nursing (DON) e FMP was initiated by but by the floor NAs. The e not expected to provide the DON stated she could not ervice to staff on the hand 0 and did not remember an r the hand splint. The DON ow why a nurse had not ed the order to the MAR/TAR had signed it. The DON bected therapy staff to aff within guidelines that hed and expected staff to when a resident had a	F 812			8/7/19
	§483.60(i) Food safet The facility must -	ty requirements.				
	state or local authorit (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using p gardens, subject to co safe growing and foo	ed satisfactory by federal, ies. ood items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/08/2019 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345313	B. WING		07/10/2019	
NAME OF PROVIDER OR SUPPLIER NORTHAMPTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE HWY 305 NORTH JACKSON, NC 27845			
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X (EACH CORRECTIVE ACTION SHOULD BE COMPL CROSS-REFERENCED TO THE APPROPRIATE DA DEFICIENCY)			
F 812	serve food in accorda standards for food se This REQUIREMENT by: Based on observatio facility failed to maint and in a sanitary con- contamination by faili under shelf for one of The findings included Review of the Dietary 8-20-13) under Clean staff were to "Clean a pan rack" and "clean weekly. During an observation 6 well steam table was underside of the stea to be covered with da A second observation 6 foot underside of th observed to be cover particles. On 7/10/19 at 2:47 PI steam table shelf was with dark dried food p touch. In an interview on 7/1 Manager stated that s table weekly and must	prepare, distribute and ance with professional rvice safety. T is not met as evidenced Ins and staff interviews the ain kitchen equipment clean dition to prevent cross ing to clean the steam table f one steam tables observed. It: Policy Manual (Version hing Assignments indicated and straighten steam table and polish steam table" In on 7/9/19 at 11:59 AM the as observed. The 6 foot in table shelf was observed ark dried food particles. In on 7/ 10/19 at 9:31 AM the e steam table shelf was ed with dark dried food M the 6 foot underside of the s observed to be covered ovarticles and was sticky to IO/19 at 3:41 PM the Dietary staff did clean the steam st have missed the	F 81	F 812 The 6 foot steam table under shell cleaned on 7/10/19 by the Dietary Manager. 100% audit of all kitchen equipme include stem table under shelves completed by 8/7/19 by the Dietar Manager. The Dietary Manager of designee will immediately clean a kitchen equipment with areas of c during the audit. 100% in-service will be completed 8/7/19 for all Dietary aides, Cooks Dietary Manager Assistant by the Manager regarding ensuring kitch equipment is cleaned and kept in sanitary condition and the procedus schedule for checking and cleanin kitchen equipment. All newly hired employees to include dietary aide cooks will be in-serviced regarding ensuring kitchen equipment is clea and kept in a sanitary condition ar procedure and schedule for check cleaning kitchen equipment during orientation by the Dietary Manage The Dietary aide and Cook will ch	ent to will be ry r ny concern d by s, and Dietary ten a ure and ng d dietary s and g aned nd the king and g er. neck	
	would clean it that ev	f. She indicated that staff ening.		kitchen equipment for cleanliness ensure in a sanitary condition dail		

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CENTERS FOR MEDICARE & N STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		345313			07/10/2019	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
NORTHAMPTON NURSING AND REHABILITATION CENTER						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		
F 812	In an interview with th 7/10/19 at 4:25 PM s	e 13 ne Director of Nursing on tated she would expect staff ble and underside of the	F 81.	prevent cross contamination to in steam table under shelves. The Manager will audit kitchen equip include steam table under shelve cleanliness and sanitation utilizir Kitchen Equipment Sanitation To X 8 weeks then monthly X 1 mor Administrator will review and init Kitchen Equipment Sanitation To X 8 weeks then monthly X 1 mor completion and to ensure all are concern that were identified were addressed to include work order. The Administrator will present the of the Kitchen Equipment Sanita to the Executive Quality Assuran committee monthly for 3 months Executive QA Committee will me monthly for 3 months and review Kitchen Equipment Sanitation To determine trends and /or issues need further interventions put int and to determine the need for fu frequency of monitoring.	Dietary ment to es for ng a pol weekly nth. The ial the pol weekly nth for as of e s. e findings tion Tools ice (QA) . The eet y the pols to that may io place	

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