| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | TE SURVEY MPLETED |
|--------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------|----------|---------------------------|
| | | 345404 | B. WING | | 1 | C 2/12/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| THREE RI | VERS HEALTH AND REF | IAB | | 403 CONNER DRIVE VINDSOR, NC 27983 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| E 000 | Initial Comments | | E 000 | | | |
| F 000 | | 5.73, Emergency I ID #0RLS11. | F 000 | | | |
| | | complaint investigation d from 12/9/19 through 0RLS11. | | | | |
| F 550 SS=D | 0 of the 5 complaint a substantiated. Resident Rights/Exer CFR(s): 483.10(a)(1) | cise of Rights | F 550 | | | 1/10/20 |
| | self-determination, an access to persons an | ht to a dignified existence, d communication with and | | | | |
| | with respect and dign resident in a manner promotes maintenance | and in an environment that e or enhancement of his or ognizing each resident's ity must protect and | | | | |
| | access to quality care severity of condition, must establish and m practices regarding tr | cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all | | | | |
| BORATORY | DIRECTOR'S OR PROVIDER/S | SUPPLIER REPRESENTATIVE'S SIGNATURI | | TITLE | | (X6) DATE |

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.

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED 0. 0938-0391 | |
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| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED | |
| | | 345404 | B. WING | | | | C 1 2/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | , | | |
| THREE RI | VERS HEALTH AND REF | IAB | | | 403 CONNER DRIVE VINDSOR, NC 27983 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 550 | residents regardless of §483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. §483.10(b)(2) The res free of interference, c reprisal from the facilit rights and to be supplexercise of his or her subpart. This REQUIREMENT by: Based on observatio interviews the facility dining experience for (Resident #27) review over him while assisti Findings included: Resident #27 was ad 2/13/15 with diagnose dementia. A review of the most n assessment (MDS) fo 10/22/19 indicated he daily decision making consciousness that file ever understood. It fu | of payment source. of Rights. right to exercise his or her i the facility and as a citizen ted States. sility must ensure that the his or her rights without a, discrimination, or reprisal sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this is not met as evidenced ns, record review and staff failed to provide a dignified one of one residents ved for dignity by standing ng with his meal. mitted to the facility on es including Alzheimer's recent Minimum Data Set | F | 550 | The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Plan for correcting specific deficiency. The process that led to deficiency cited On 12/09/2019, Resident #27 was | l ken on | | |

Facility ID: 953224

If continuation sheet Page 2 of 24

| | OF DEFICIENCIES | MEDICAID SERVICES | (X2) MULTIP | LE CONSTRUCTION | | NO. 0938-039 ATE SURVEY |
|---------------|------------------------|------------------------------------------------------------|---------------|---------------------------------------------------------------|----------------|----------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | . , | | | OMPLETED |
| | | | | | | С |
| | | 345404 | B. WING | | | 12/12/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | | 12,12,2010 |
| | | | | 1403 CONNER DRIVE | | |
| THREE RI | VERS HEALTH AND REI | HAB | | WINDSOR, NC 27983 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF (| CORRECTION | (X5) |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC | HE APPROPRIATE | COMPLETION |
| F 550 | Continued From page | e 2 | F 55 | 50 | | |
| | | | | assisted by LPN Support N | urse during | |
| | A review of the most | - | | meal time by standing while | | |
| | | ed a focus area of requires | | and assisting with his meal. | | |
| | | ities of daily living and at risk | | | | |
| | · · | ated to dependence with a | | On 12/9/2019, the LPN Sup | • | |
| | | or improve current level of | | was re-educated by the Dire | | |
| | | review and interventions | | Nursing on the dining exper | | |
| | U 1 | al assistance to eat and | | states staff should be seate | • | |
| | - · · | ticipate to my fullest extent | | 2. The procedure for implem | | |
| | with every interaction | I. | | acceptable plan of correction specific deficiency cited: - | n- Ior the | |
| | On 12/9/19 at 12:25 I | PM Nurse #1 was observed | | specific denoiciney cited. | | |
| | | sisting Resident #27 with his | | On 12-10-17, The Administ | rator and | |
| | - | #27 was seated in a recliner | | Director of Nursing began in | | |
| | | /as standing to his side, | | FT, PT, and PRN RN's and | | |
| | feeding him. Residen | - | | CNA's on the following proc | | |
| | | rim and could not make eye | | | | |
| | contact with Nurse # | 1 during the activity. | | Resident Dignity - Sitting be | eside a | |
| | | | | resident while feeding them | instead of | |
| | On 12/9/19 at 12:30 | PM Nurse Aide #1 was | | standing up to feed. | | |
| | observed to walk into | the dining room and say to | | | | |
| | | to sit down". Nurse #1 was | | Any in-house staff member | who did not | |
| | | ?' and then observed to sit in | | receive in-service training b | - | |
| | a chair beside Reside | ent #27. | | will not be allowed to work u | - | |
| | | | | has been completed. This in | | |
| | | PM an interview with Nurse | | been integrated into the sta | | |
| | | familiar with Resident #27 | | orientation training and in th | | |
| | | with meals before. She | | in-service refresher courses | | |
| | | se Aide #1 tell her to sit assisting Resident #27 with | | employees and will be revie | - | |
| | | not know why Nurse Aide #1 | | Quality Assurance process the change has been sustai | • | |
| | | ent on to say sometimes she | | | | |
| | | ting residents with meals but | | The monitoring procedure to | o ensure that | |
| | | d up when feeding them. She | | the plan of correction is effe | | |
| | | r standing up while feeding | | specific deficiency cited ren | | |
| | | mething she ever really | | and/or in compliance with th | | |
| | | #1 indicated that she | | requirements: | | |
| | | for her to reach Resident | | | | |
| | #27's food while she | | | The Administrator, Director | of Nuraina or | |

Facility ID: 953224

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-0391 | |
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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , í | PLE CONSTRUCTION 3 | | LETED |
| | | 345404 | B. WING | | | C 12/2019 |
| NAME OF PR | ROVIDER OR SUPPLIER | | • | STREET ADDRESS, CITY, STATE, ZIP CODE | · | |
| | | | | 1403 CONNER DRIVE | | |
| | VERS HEALTH AND REF | | | WINDSOR, NC 27983 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 550 | Aide #1 indicated the annual in-services reg with dignity. She state level with residents w meals. On 12/9/19 at 1:12 Pf Director of Nursing (D received training in tre within the last year wh level with residents w meals. She stated Nu seated next to Reside and Nurse #27 knew standing over a seate with meals would not On 12/9/19 at 1:17 Pf Resident #27 was uns | M an interview with Nurse facility provided staff with garding treating residents ad this included sitting at eye hen assisting them with M an interview with the DON) indicated Nurse #1 eating residents with dignity hich included sitting at eye hile assisting them with rse #1 should have been ent #27 while feeding him that. The DON added staff d resident while assisting be appropriate. M an attempt to interview successful. | F 55 | Support Nurse will conduct audits to ensure the staff are providing a dignifie dining experience and staff are seated eye level. These audits will be conduct weekly for two weeks and monthly for 3 months. This monitoring will continue us resolved by QOL/QA committee. Repo will be presented to the weekly QA committee by the Administrator or DON ensure corrective action initiated as appropriate. Compliance will be monito and ongoing auditing program reviewed the weekly QA Meeting. The weekly QA Meeting is attended by the Administrato DON, MDS Coordinator, Therapy, HIM and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction. | at ted 3 intil rts N to ored d at A or, | |
| F 641 SS=E | Administrator indicate been aware of the ner residents when assist had received training dignity which included residents when assist the last year. She stat was just having a bad Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status. | ents | F 64 | Date of Compliance: 01/09/2020 | | 1/9/20 |

Facility ID: 953224

If continuation sheet Page 4 of 24

| | - | ND HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 01/15/2020 MAPPROVED D. 0938-0391 | |
|--------------------------|-------------------------------|---------------------------------------------------------------------------------------|-------------------|-----|----------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------|--|
| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
| | | 345404 | B. WING | | | | C 12/2019 | |
| NAME OF PF | ROVIDER OR SUPPLIER | • | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THREE RIV | VERS HEALTH AND REI | HAB | | | 403 CONNER DRIVE VINDSOR, NC 27983 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 641 | Continued From page | e 4 | F | 641 | | | | |
| | • | iew and staff interviews, the | | | F641 | | | |
| | | ately code the Minimum | | | The statements made on this plan of | | | |
| | () | or 19 resident records | | | correction are not an admission to and | l do | | |
| | | curacy (Residents #49, #28, | | | not constitute an agreement with the alleged deficiencies. | | | |
| | #15, #11, and #39). | | | | To remain in compliance with all federa | al | | |
| | Findings included: | | | | and state regulations the facility has ta | | | |
| | | | | | or will take the actions set forth in this | | | |
| | 1. Resident #49 was | admitted to the facility on | | | plan of correction. The plan of correction | on | | |
| | 08/07/18 with diagnos | | | | constitutes the facility's allegation of | | | |
| | hypertension and nor | n-Alzheimer's dementia. | | | compliance such that all alleged | | | |
| | | | | | deficiencies cited have been or will be | | | |
| | | erly MDS assessment dated at Resident #49 was not | | | corrected by the dates indicated. | | | |
| | | uard and did not exhibit | | | | | | |
| | wandering behaviors | | | | Plan for correcting specific deficiency. | The | | |
| | wandoning bonavioro | • | | | process that led to deficiency cited. | mo | | |
| | A review of the annua | al MDS assessment dated | | | ······, ······ | | | |
| | 8/15/19 indicated that | t Resident #49 was coded | | | | | | |
| | for a wanderguard ar | nd did not exhibit wandering | | | The facility failed to accurately code th | | | |
| | behaviors. | | | | Minimum Data Set (MDS) for 5 Reside Residents #49, #28, #15, #11, and #39 | | | |
| | | cian's orders revealed an | | | | | | |
| | - | d dated 8/09/19 for Resident | | | | 4.41= = | | |
| | #49. | | | | 1. On 12/10/19, it was identified tha MDS Assessment for Resident #49 da | | | |
| | A review of the Nove | mber Medication | | | 11/15/2019 was incorrect and assess | | | |
| | | d (MAR) revealed there was | | | should have reflected Resident | | | |
| | | check that Resident #49's | | | wanderguard alarm as being used dail | y. | | |
| | wanderguard bracele | | | | 2. On 12/11/2019, it was identified th | - | | |
| | | | | | the MDS Assessment for Resident #28 | 3 | | |
| | | vith the MDS Coordinator on | | | dated 10/28/2019 was incorrect and | | | |
| | | 1, she revealed that the MDS | | | should have accurately reflected exhib | oited | | |
| | | dent #49 dated 11/15/19 was | | | behaviors. | t | | |
| | incorrect and should | nave reflected her is being used daily. She | | | 3. On 12/11/2019, it was identified the MDS Assessment for Resident #15 | | | |
| | - | e made a mistake and had | | | dated 09/27/2019 was incorrect and | | | |
| | | on the quarterly MDS. | | | should have accurately reflected hospi | ice | | |

Facility ID: 953224

If continuation sheet Page 5 of 24

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | | E SURVEY IPLETED |
|--------------------------|-------------------------------|----------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------|-----------------------------------|----------------------------|
| | | 345404 | B. WING | | 12 | C 2/12/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | CODE | | |
| THREE RI | VERS HEALTH AND RE | HAB | | 1403 CONNER DRIVE WINDSOR, NC 27983 | | |
| | | | | PROVIDER'S PLAN O | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETIOI DATE |
| F 641 | Continued From page | e 5 | F 6 | 41 | | |
| | | | | services. | | |
| | | vith the Administrator on | | 4. On 12/12/2019, it was | s identified that | |
| | | she stated the MDS for | | the MDS Assessment for | | |
| | | have been coded correctly | | dated 11/11/2019 was inc | | |
| | and she did not know | v why it had not been done. | | should have accurately re | flected exhibited | |
| | | | | behaviors. 5. On 12/11/2019, it was | e identified that | |
| | | | | the MDS Assessment for | | |
| | 2. Resident #28 was | admitted to the facility on | | dated 06/28/2019 was inc | | |
| | | ses that included heart | | should have reflected a st | | |
| | failure and diabetes. | | | ulcer. | 0 | |
| | A nurse 's note date | | | 2. The procedure for imple | | |
| | | ed behaviors such as yelling, | | acceptable plan of correct | | |
| | screaming and cursir | ng. | | specific deficiency cited: - | | |
| | Resident #28 ' s mini | imum data sat (MDS) | | 1. On 12/30/19 and 12/ Assessment for Resident | | |
| | | D/28/19, an admission | | 11/15/2019 was corrected | | |
| | | in Section E no behaviors. | | accurately reflect Resider | | |
| | | | | alarm as being used daily | | |
| | During an interview o | on 12/11/19 at 2:32 PM the | | 2. On 12/30/19 and 12/3 | | |
| | - | ported Resident #28 ' s MDS | | Assessment for Resident | #28 dated | |
| | | nave accurately reflected | | 10/28/2019 was corrected | | |
| | | ed Section E of the MDS | | accurately reflect exhibite | | |
| | assessment was con | npleted by social work. | | 3. On 12/30/19 and 12/3 | | |
| | An interview was | ductod on 12/12/10 at 0.00 | | Assessment for Resident 09/27/2019 was corrected | | |
| | | nducted on 12/12/19 at 9:00 erviced Assistant who stated | | accurately reflect hospice | | |
| | | esident #28 ' s progress | | 4. On 12/30/19 and 12/3 | | |
| | notes to complete Se | | | Assessment for Resident | | |
| | assessment dated 10 | | | 11/11/2019 was corrected | | |
| | | | | accurately reflect exhibite | | |
| | | on 12/12/19 at 11:00 AM the | | 5. On 12/30/19 and 12/3 | | |
| | | ed Resident #28 ' s MDS | | Assessment for Resident | | |
| | | nave accurately reflected | | 06/28/2019 was corrected | | |
| | exhibited behaviors. | | | reflect a stage 2 pressure | ulcer. | |
| | | admitted to the facility | | All residents have the pot | | |
| | 6/16/17 with diagnos | es that included | | affected by the alleged de | eticient practice. | |

Facility ID: 953224

If continuation sheet Page 6 of 24

| | | | | | | OMB NO | MAPPROVE 0.0938-039 | |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|----------------------------------------|-----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------|--|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | | |
| | | 345404 | B. WING _ | | | | 12/2019 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THREE RI | VERS HEALTH AND REI | НАВ | | 14 | 03 CONNER DRIVE | | | |
| | | | | W | INDSOR, NC 27983 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | ЗE | (X5) COMPLETION DATE | |
| F 641 | Continued From page | e 6 | F 6 | 341 | | | | |
| | hypertension and dia | | | | A 100% audit was completed for all residents in order to identify any other | s | | |
| | A doctor ' s order date to admit Resident #1 | ed 7/7/19 revealed an order 5 to hospice. | | | who were affected. The audit results a below: | | | |
| | Resident #15 ' s minimum data set (MDS) assessment dated 9/27/19 revealed Resident #15 was not coded in Section J as receiving hospice services. During an interview on 12/11/19 at 2:32 PM the MDS Coordinator reported Resident #15 ' s MDS assessment should have accurately reflected hospice services. She indicated this was an error. | | | | 0 of 2 residents who wear Wandergua bracelets were identified with inaccura coding of Alarms in Section P of their most recent MDS assessment. | | | |
| | | | | | 0 of 0 residents who are receiving Hospice services were identified with inaccurate coding of Prognosis in Sec J1400 of their most recent MDS assessment. 2 of 21 residents who have had a Pressure Ulcer during the past 30 day | | | |
| | administrator indicate | on 12/12/19 at 11:00 AM the ed Resident #15 ' s MDS have accurately reflected | | | were identified with inaccurate coding Pressure Ulcers in Section M of their I assessment. 1 of 52 residents who have document Behaviors during the past 30 days we | of MDS ed | | |
| | | admitted to the facility on es that included heart failure | | | identified with inaccurate coding of Section E of their MDS assessment. | | | |
| | | d 11/10/19 revealed Resident iors such as agitation and | | | These audits were completed by the M Coordinator, Social Services Assistant and the Administrator on 01/08/20. All MDSs identified with inaccurate co of audited areas were modified and | t | | |
| | assessment dated 11 | mum data set (MDS) I/11/19, an admission I in Section E no behaviors. | | | corrected by the MDS Coordinator on 01/03/20 and 01/07/2020. The correct assessments for pressure ulcers were re-submitted to the state database on | | | |
| | MDS Coordinator rep assessment should h | on 12/11/19 at 2:32 PM the ported Resident #39 ' s MDS have accurately reflected ad Section E of the MDS | | | 01/07/20. The Batch #1392. The corrected assessments for behaviors completed and submitted to the state its due date 01/17/2020. | | | |
| | assessment was com | npleted by social work. | | | The above-mentioned MDS assessme | ents | | |

Facility ID: 953224

If continuation sheet Page 7 of 24

| | | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (¥2) MI II TI | PLE CONSTRUCTION | | NO. 0938-039 DATE SURVEY |
|--------------------------|------------------------|-----------------------------------------------------------------------------------------|---------------------|-------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | ` ´ | G | | OMPLETED |
| | | | V. DOILDIN | | | С |
| | | 345404 | B. WING | | _ | 12/12/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STA | ATE, ZIP CODE | 12/12/2013 |
| | | | | 1403 CONNER DRIVE | | |
| THREE R | VERS HEALTH AND RE | HAB | | WINDSOR, NC 27983 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 641 | Continued From page | o 7 | | | | |
| 1 041 | - 15 | e 7 nducted on 12/12/19 at 9:00 | F 6 | | | |
| | | erviced Assistant who stated | | on 12/30/19 and 12 | he facility MDS nurse | |
| | | esident #39 ' s progress | | re-submitted to the | | |
| | notes to complete Se | ection E of the MDS | | | | |
| | assessment dated 10 | J/28/19. | | On 12/21/10 The M | IDC Concultant | |
| | During an interview o | on 12/12/19 at 11:00 AM the | | On 12/31/19, The M in-serviced the MDS | | |
| | • | ed Resident #39 ' s MDS | | Admissions Coordin | | |
| | | nave accurately reflected | | - | on how to accurately | |
| | exhibited behaviors. | ········, · ··· | | code behaviors, ala | - | |
| | 6.Resident #11 was a | admitted to the facility on | | medications, hospic | | |
| | 8/9/18 with diagnose | s including dementia without | | wounds(completed | 01/02/2020) on the | |
| | behavioral disturbance | ce. | | MDS assessment. | | |
| | | | | | portance of thoroughly | |
| | | m Data Set assessment | | | t's complete medical | |
| | | #11 dated 6/28/19 indicated I pressure ulcers or injuries. | | | ogress notes, orders, atment administration | |
| | | pressure dicers of injuries. | | | sistant documentation, | |
| | A review of a nursing | progress note dated 6/21/19 | | | answers on the MDS | |
| | | Resident #11 had a sacral | | | education also included | |
| | | id and the wound care | | the importance of ir | nterviewing staff | |
| | physician had exami | ned her. | | members as well as | | |
| | | | | resident prior to coo | ding the MDS | |
| | | progress note for Resident | | assessment. | | |
| | #11 dated 6/24/19 at | | | | | |
| | | stage two (shallow open | | This information ha | a been integrated into | |
| | area) pressure ulcer | | | | s been integrated into ation training for new | |
| | A review of a nursing | progress note dated 6/25/19 | | MDS Coordinators, | | |
| | | Resident #11 had a stage | | | ocial Services staff | |
| | two pressure ulcer to | • | | | in-service refresher | |
| | | | | courses for all empl | | |
| | | AM interview with the MDS | | reviewed by the Qu | | |
| | | d she completed the 6/28/19 | | process to verify the | at the change has | |
| | | ident #11 regarding pressure | | been sustained. | | |
| | | the assessment period for | | | 1 1 A A | |
| | | /21/19 through 6/28/19. The | | | cedure to ensure that | |
| | | ent on to say she obtained | | | on is effective and that | |
| | I ner mormation by re | viewing progress notes, skin | | | cited remains corrected | 1 |

Facility ID: 953224

If continuation sheet Page 8 of 24

| | - | ID HUMAN SERVICES | 1 | | | FORM |): 01/15/202 1 APPROVEI). 0938-039 |
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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | | (X3) DATE SURVEY COMPLETED | |
| | | 345404 | B. WING | | | | _ 12/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | VERS HEALTH AND REF | 1AB | | 14 | 03 CONNER DRIVE | | |
| | | | | W | INDSOR, NC 27983 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 641 | assessment period w of the MDS for reside the progress notes for pressure ulcer should MDS assessment but On 12/12/19 at 12:44 Administrator and Din Resident #11's stage documented in her pr | und care notes for the hen completing this section nts. She indicated based on r Resident #11, her stage 2 I have been reflected on her t was not. PM an interview with the ector of Nursing indicated | F 6- | 41 | and/or in compliance with the regulator requirements: The Administrator, Director of Nursing MDS Consultant will conduct audits to ensure the MDS are coded accurately using the QA audit tool entitled "MDS Coding Accuracy QA Tool." These aud will be conducted weekly for two weeks and monthly for 3 months. This monitor will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure correct action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at weekly QA Meeting. The weekly QA Meeting is attended by the Administrator DON, MDS Coordinator, Therapy, HIM and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction. Date of Compliance: | or lits s ring tive the or, | |
| F 655 SS=E | | -(3) sive Person-Centered Care | F 6 | 55 | 01/09/2020 | | 1/9/20 |
| | | Care Plans cility must develop and care plan for each resident | | | | | |

Facility ID: 953224

If continuation sheet Page 9 of 24

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
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| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | • • | | E CONSTRUCTION | (X3) DATE COMP | |
| | | 345404 | B. WING | | | | _ 12/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| THREE RI | VERS HEALTH AND REF | IAB | | | 1403 CONNER DRIVE WINDSOR, NC 27983 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 655 | that includes the instr effective and person- that meet professional The baseline care pla (i) Be developed within admission. (ii) Include the minimun necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (E) Social services. (F) PASARR recomm §483.21(a)(2) The fact comprehensive care plan if the compre- (i) Is developed within admission. (ii) Meets the requirer (b) of this section (exc this section). §483.21(a)(3) The fa- resident and their rep of the baseline care plimited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the fa- on behalf of the facilit (iv) Any updated infor- of the comprehensive | uctions needed to provide centered care of the resident al standards of quality care. In must- in 48 hours of a resident's um healthcare information care for a resident ted to- l on admission orders. endation, if applicable. cility may develop a blan in place of the baseline rehensive care plan- n 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary lan that includes but is not if the resident. resident is medications and treatments to be acility and personnel acting | F | 655 | | | |

Facility ID: 953224

If continuation sheet Page 10 of 24

| | S FOR MEDICARE & | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | דוסי ר | CONSTRUCTION | | <u>D. 0938-039</u> E SURVEY | |
|--------------------------|------------------------|----------------------------------------------------------------------------------------|--------------------|--------|----------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------|--|
| | CORRECTION | IDENTIFICATION NUMBER: | · / | | | COMPLETED | | |
| | | 345404 | B. WING | | | C 12/12/2019 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| | VERS HEALTH AND RE | HAB | | 14 | 403 CONNER DRIVE | | | |
| | | | | N | VINDSOR, NC 27983 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 655 | Continued From page | e 10 | Í F | 655 | | | | |
| | | view, resident and staff | | 000 | F655 | | | |
| | | failed to provide a summary | | | The statements made on this plan of | | | |
| | - | plan to residents or their | | | correction are not an admission to and | do l | | |
| | | of 6 residents reviewed for | | | not constitute an agreement with the | | | |
| | | Resident #28, Resident #55, | | | alleged deficiencies. | | | |
| | Resident #39, Reside | ent #8 and Resident #34). | | | To remain in compliance with all federa | al | | |
| | | | | | and state regulations the facility has ta | aken | | |
| | The findings included | 1: | | | or will take the actions set forth in this | | | |
| | | | | | plan of correction. The plan of correcti | on | | |
| | | admitted to the facility on | | | constitutes the facility's allegation of | | | |
| | | ses that included heart | | | compliance such that all alleged | | | |
| | failure and diabetes. | | | | deficiencies cited have been or will be | | | |
| | • · · · · | | | | corrected by the dates indicated. | | | |
| | | current Minimum Data Set | | | Dian for correcting energific deficiency | The | | |
| | | lated 10/28/19 indicated he | | | Plan for correcting specific deficiency. | The | | |
| | was cognitively intact | ι. | | | process that led to deficiency cited. | | | |
| | A review of the most | current care plan for | | | The facility failed to provide a summar | v of | | |
| | | 10/22/19 indicated focus | | | the baseline care plan to residents or t | | | |
| | areas including medi | cation risks, activities of daily | | | representatives for 5 of 6 residents | | | |
| | - | dressing, bathing and | | | reviewed for baseline care plans. | | | |
| | grooming, and fall ris | k with goals that were | | | Residents #28, #55, #39, #8, and #34. | | | |
| | measurable and inter | rventions which were | | | | | | |
| | individualized. | | | | 1. On 12/11/19, it was identified tha | | | |
| | | | | | Resident #28 nor his representative ha | ad | | |
| | |) AM an interview with | | | received a written summary of his | | | |
| | | ed he did not recall receiving | | | baseline care plan. | | | |
| | | f his baseline care plan. He | | | 2. On 12/11/19, it was identified that | | | |
| | uenieu naving any co | oncerns related to his care. | | | Resident #55 nor his representative har received a written summary of his | au | | |
| | On 12/11/10 at 2.34 I | PM the MDS Coordinator | | | baseline care plan. | | | |
| | indicated neither Res | | | | 3. On 12/11/19, it was identified that | | | |
| | | eceived a written summary of | | | Resident #39 nor his representative ha | | | |
| | | n. She stated she normally | | | received a written summary of his | | | |
| | | er representatives a written | | | baseline care plan. | | | |
| | - | nmary report which they | | | 4. On 12/12/19, it was identified that | : | | |
| | | knowledge receipt, but it was | | | Resident #8 nor his representative had | | | |
| | not provided to Resid | - · | | | received a written summary of his | | | |
| | - | | | | baseline care plan. | | | |

Facility ID: 953224

| | | ND HUMAN SERVICES MEDICAID SERVICES | | | | FC | TED: 01/15/202 DRM APPROVE NO. 0938-039 | |
|--------------------------|-------------------------------|---------------------------------------------------------------------------------------|--------------------|-----|---------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------|--|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` <i>`</i> | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 345404 | B. WING | | | C 12/12/2019 | | |
| NAME OF PR | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| | | | | 1 | 403 CONNER DRIVE | | | |
| THREE RI | VERS HEALTH AND REI | НАВ | | v | VINDSOR, NC 27983 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | ЗE | (X5) COMPLETION DATE | |
| F 655 | Continued From page | o 11 | _ | 655 | | | | |
| 1 000 | | | | 055 | | | | |
| | | vith the Administrator on with the Administrator she | | | 5. On 12/12/19, it was identified that Resident #34 nor his representative h | | | |
| | | acility 's practice to provide | | | Resident #34 nor his representative has received a written summary of his | au | | |
| | | resentatives with an order | | | baseline care plan. | | | |
| | - | h would include initial goals, | | | | | | |
| | • • | tary orders, and therapy | | | 2. The procedure for implementing the | , | | |
| | | d as the written summary of | | | acceptable plan of correction- for the | • | | |
| | | n. She continued to state | | | specific deficiency cited: - | | | |
| | Resident #28 should | | | | | | | |
| | information. | | | | 1. On 01/03/2019, Resident #28 wa | IS | | |
| | | | | | provided a written summary of his | | | |
| | 2. Resident #55 was | admitted to the facility on | | | baseline care plan. | | | |
| | 11/20/19 with diagnos | ses that included | | | 2. On 01/03/2019, Resident #55was | ; | | |
| | hypertension. | | | | provided a written summary of his | | | |
| | | | | | baseline care plan. | | | |
| | A review of Resident | | | | 3. On 01/03/2019, Resident #39's | | | |
| | | IDS) assessment dated | | | representative was provided a written | | | |
| | 10/28/19 indicated sh | ne was cognitively intact. | | | summary of his baseline care plan. | | | |
| | | | | | 4. Resident #8 was discharged from | the | | |
| | A review of the most | - | | | facility on 12/26/2019. | | | |
| | | 12/10/19 indicated focus | | | 5. Resident #34 was discharged from | m | | |
| | | cation risks, activities of daily dressing, bathing and | | | the facility on 12/11/2019. | | | |
| | • | k with goals that were | | | All residents have the potential for bei | na | | |
| | measurable and inter | - | | | affected by the above alleged deficien | | | |
| | individualized. | | | | practice. On 01/03/2020, a 100% aud | | | |
| | | | | | all residents who have been admitted | | | |
| | On 12/10/19 at 11:45 | AM an interview with | | | the facility during the past 30 days wa | | | |
| | Resident #55 indicate | | | | completed to validate whether or not a | | | |
| | | immary of her baseline care | | | Baseline Care Plan had been complet | | | |
| | - | aving any concerns related to | | | and reviewed with the resident or not. | | | |
| | her care. | | | | The audit results are as follows: | | | |
| | | | | | 3 of 11 residents reviewed were identi | fied | | |
| | On 12/11/19 at 2:34 F | PM the MDS Coordinator | | | as not having had a Baseline Care Pla | an | | |
| | indicated neither Res | ident #55 or her | | | completed as required. | | | |
| | - | eceived a written summary of | | | | | | |
| | | n. She stated she normally | | | All residents who were identified as no | ot | | |
| | | ir representatives a written | | | having the Baseline Care Plan | | | |
| | copy of the order sun | nmary report which they | | | requirement met were provided a writt | en | | |

Facility ID: 953224

If continuation sheet Page 12 of 24

| | | ND HUMAN SERVICES MEDICAID SERVICES | | | | FOR | D: 01/15/202 MAPPROVEI O. 0938-039 |
|--------------------------|-----------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------|--------------|-----------------------------------------------------------------------------------------------------------------|-------------|------------------------------------------|
| STATEMENT | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | `, ´ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 345404 | B. WING _ | | | 12 | C 2/ 12/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | • | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 14 | 03 CONNER DRIVE | | |
| THREE RI | VERS HEALTH AND RE | НАВ | | W | INDSOR, NC 27983 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX (EACH CORRECTIVE) TAG CROSS-REFERENCED | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 655 | Continued From page | e 12 | F | 655 | | | |
| 1 000 | | knowledge receipt, but it was | | 555 | summary of his/bor Resoling Core D | on if | |
| | not provided to Resid | | | | summary of his/her Baseline Care Pl they were still a current, active Resid residing in the facility. | | |
| | During an interview v | vith the Administrator on | | | <u> </u> | | |
| | | with the Administrator she | | | On 12-31-19, The MDS Consultant | | |
| | | acility 's practice to provide | | | in-serviced the MDS Coordinator, | | |
| | - | resentatives with an order | | | Admissions Coordinator and Social | -11 | |
| | | h would include initial goals, tary orders, and therapy | | | Services Assistant on the requirement completing a Baseline Care Plan for | | |
| | | d as the written summary of | | | admitted residents within 48 hours of | | |
| | | n. She continued to state | | | admission to facility. This requireme | | |
| | Resident #55 should | | | | also includes providing all residents | | |
| | information. | | | | and/or their representative with a wri | tten | |
| | | | | | and signed summary of their care | | |
| | | admitted to the facility on | | | (Baseline Care Plan). This process i | | |
| | - | es that included heart failure | | | completed by ensuring that all orders | | |
| | and diabetes. | | | | medications, mental health/social set | vice | |
| | A review of the most | current Minimum Data Set | | | needs, therapy services, PASRR follow-up/review needs, resident's in | nitial | |
| | | lated 11/11/19 indicated she | | | goals and dietary needs are included | | |
| | was cognitively impa | | | | their order summary. At the time of t | | |
| | 0 , 1 | | | | resident's 72 hour care plan meeting | | |
| | A review of the most | current care plan for | | | Order Summary Report, which serve | s as | |
| | | 11/4/19 indicated focus areas | | | the Baseline Care Plan is printed and | | |
| | • | risks, activities of daily living | | | reviewed with the resident and/or res | | |
| | | ing, bathing and grooming, | | | representative. The Order Summary | | |
| | interventions which w | ls that were measurable and | | | Report/Baseline Care Plan is then sig | gnea | |
| | | | | | by a nurse and the resident and/or representative. The resident and/or | | |
| | On 12/11/19 at 2:34 I | PM the MDS Coordinator | | | representative is given a signed copy | / and | |
| | indicated neither Res | | | | the facility maintains a signed copy of | | |
| | | eceived a written summary of | | | Baseline Care Plan. The facility copy | | |
| | | n. She stated she normally | | | should be uploaded into the resident | 's | |
| | | eir representatives a written | | | electronic health record in Point Click | ¢ | |
| | | nmary report which they | | | Care. | | |
| | - | knowledge receipt, but it was | | | This is former of the total of the | · · · · 4 · | |
| | not provided to Resid | Jent #39. | | | This information has been integrated | | |
| | During an interview w | vith the Administrator on | | | the standard orientation training for n MDS Coordinators, Social Services | ew | |
| | | | | | | | |

Facility ID: 953224

If continuation sheet Page 13 of 24

| | OF DEFICIENCIES | MEDICAID SERVICES | (X2) MULT | | CONSTRUCTION | (X3) DATE | |
|--------------------------|-----------------------|---------------------------------------------------------------------------------------|---------------------|-----|----------------------------------------------------------------------------------------------------------------------|-----------|---------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | · , | | | · / | PLETED |
| | | | A. BOILDIN | ··· | | | С |
| | | 345404 | B. WING | | | | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 14 | 03 CONNER DRIVE | | |
| THREE RI | VERS HEALTH AND RE | НАВ | | W | INDSOR, NC 27983 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETIO DATE |
| F 655 | Continued From non | o 12 | 50 | | | | |
| F 055 | | | F 6 | 55 | Assistante and Admissions Dissetant | | |
| | | with the Administrator she acility ' s practice to provide | | | Assistants and Admissions Directors a in the required in-service refresher | па | |
| | | resentatives with an order | | | courses for these employees and will b | he | |
| | | h would include initial goals, | | | reviewed by the Quality Assurance | | |
| | | tary orders, and therapy | | | process to verify that the change has | | |
| | | d as the written summary of | | | been sustained. | | |
| | the baseline care pla | n. She continued to state | | | | | |
| | Resident #39 should | have received this | | | The monitoring procedure to ensure th | | |
| | information. | | | | the plan of correction is effective and the | | |
| | | | | | specific deficiency cited remains correct | | |
| | 1 Decident #9 was a | dmitted to the facility on | | | and/or in compliance with the regulator | ry | |
| | | dmitted to the facility on es including dementia. | | | requirements: | | |
| | | | | | The Administrator, Director of Nursing | or | |
| | | current Minimum Data Set | | | MDS Consultant will conduct audits to | | |
| | . , | lated 8/29/19 indicated | | | ensure the baseline care process is | | |
| | | ependent with daily decision | | | provided to Residents and or Resident Representative. These audits will be | | |
| | making. | | | | conducted weekly for two weeks and | | |
| | A review of the most | current care plan for | | | monthly for 3 months. This monitoring | will | |
| | | 23/19 indicated focus areas | | | continue until resolved by QOL/QA | | |
| | | risks, activities of daily living | | | committee. Reports will be presented t | 0 | |
| | needs such as dress | ing, bathing and grooming, | | | the weekly QA committee by the | | |
| | - | s that were measurable and | | | Administrator or DON to ensure correct | tive | |
| | interventions which w | vere individualized. | | | action initiated as appropriate. | | |
| | 0- 40/40/40 -+ 0-00 | | | | Compliance will be monitored and | 41 | |
| | On 12/12/19 at 9:00 | | | | ongoing auditing program reviewed at | the | |
| | | d he did not recall receiving a is baseline care plan. He | | | weekly QA Meeting. The weekly QA Meeting is attended by the Administrat | or | |
| | | lid not have any concerns or | | | DON, MDS Coordinator, Therapy, HIM | | |
| | | his care and was being taken | | | and the Dietary Manager. | | |
| | of. | 5 | | | The title of the person responsible for | | |
| | | | | | implementing the plan of correction. | | |
| | | AM interview with the MDS | | | The Administrator is responsible for | | |
| | | d neither Resident #8 or his | | | implementation and completion of the | | |
| | - | eceived a written copy of his | | | acceptable plan of correction. | | |
| | - | the went on to say she ts or their representatives a | | | Date of Compliance: | | |
| | | nmary report which they | | | | | |

Facility ID: 953224

If continuation sheet Page 14 of 24

| | MENT OF HEALTH AN | | | | | FORM | APPROVED |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPL | E CONSTRUCTION | OMB NO. 0938-0391 (X3) DATE SURVEY | |
| AND PLAN O | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | ING . | | COMP | LETED |
| | | 345404 | B. WING | | | | C 12/2019 |
| NAME OF F | ROVIDER OR SUPPLIER | | | ; | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 12/ | 12/2013 |
| | | | | | 1403 CONNER DRIVE | | |
| IHREE R | IVERS HEALTH AND REF | 148 | WINDSOR, NC 27983 | | | | |
| (X4) ID PREFIX TAG | | | ID PREF TAG | IX (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) COMPLETION DATE |
| F 655 | signed to acknowledg why she had not prov Resident #8 or his rep On 12/12/19 at 9:13 <i>A</i> Administrator indicate practice to provide res representatives with a which would include in orders, dietary orders served as the baselin summary. The Admin information had not b or his representative. missed. 5.Resident #34 was a 10/30/19 with diagnos She was discharged f 12/11/19. A review of the most of (MDS) assessment for 11/6/19 indicated Res with daily decision ma A review of the most of Resident #34 dated 1 areas including medio living needs such as of grooming, and fall rist measurable and inter individualized. On 12/10/19 at 10:32 Resident #34 indicate receiving a written co | pe receiving but did not know ided this information to presentative. AM an interview with the ed it was the facility's sidents or their an order summary report nitial goals, physician and therapy services which e care plan written istrator went on to say this een provided to Resident #8 She stated it just got admitted to the facility on ses including heart failure. from the facility to home on current Minimum Data Set or Resident #34 dated sident #34 was independent aking. current care plan for 0/31/19 indicated focus cation risks, activities of daily dressing, bathing and k with goals that were ventions which were AM an interview with | F | 655 | | | |

Facility ID: 953224

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| | | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED 0. 0938-0391 |
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| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 345404 | B. WING | | | | C / 12/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | - | | | | |
| THREE RI | VERS HEALTH AND REF | IAB | | | 1403 CONNER DRIVE WINDSOR, NC 27983 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | (X5) COMPLETION DATE |
| F 655 F 758 SS=D | not have any question On 12/12/19 at 10:34 Coordinator indicated representative had re baseline care plan be went on to say she us representatives a cop report which they sign receiving but did not k provided this informat representative. On 12/12/19 at 9:13 A Administrator indicate practice to provide re- representatives with a which would include i orders, dietary orders served as the baselin summary. The Admin information had not b #34 or her representa She stated it just got Free from Unnec Psy CFR(s): 483.45(c)(3)(§483.45(c)(3) A psyct affects brain activities | AM interview with the MDS neither Resident #34 or her ceived a written copy of her fore her discharge. She sually gave residents or their y of the order summary hed to acknowledge know why she had not tion to Resident #34 or her AM an interview with the ed it was the facility's sidents or their an order summary report nitial goals, physician and therapy services which e care plan written istrator went on to say this een provided to Resident tive before her discharge. missed chotropic Meds/PRN Use (e)(1)-(5) pic Drugs. notropic drug is any drug that associated with mental ior. These drugs include, | | 655 | | | 1/9/20 |

Event ID: 0RLS11

Facility ID: 953224

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
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| STATEMENT O | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPLE | E CONSTRUCTION | (X3) DATE SURVEY | |
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | ING _ | | | LETED |
| | | 345404 | B. WING | | | | C 12/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 12/ | 12/2013 |
| THREE RI | VERS HEALTH AND REF | IAB | | | | | |
| | SI IMMARY ST | ATEMENT OF DEFICIENCIES | ID | | WINDSOR, NC 27983 PROVIDER'S PLAN OF CORRECTION | | (¥5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CALL CONTRACTORY OF LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETION DATE | | | |
| F 758 | Continued From page | e 16 | F | 758 | | | |
| | Based on a comprehensive assessment of a resident, the facility must ensure that | | | | | | |
| | psychotropic drugs ar unless the medication | nts who have not used re not given these drugs n is necessary to treat a diagnosed and documented | | | | | |
| | drugs receive gradual behavioral interventio | nts who use psychotropic I dose reductions, and ons, unless clinically a effort to discontinue these | | | | | |
| | unless that medicatio | ursuant to a PRN order n is necessary to treat a andition that is documented | | | | | |
| | are limited to 14 days §483.45(e)(5), if the a prescribing practitione appropriate for the PF beyond 14 days, he o | er believes that it is RN order to be extended or she should document their ent's medical record and | | | | | |
| | drugs are limited to 14 renewed unless the a prescribing practitione the appropriateness of This REQUIREMENT by: Based on record revi | ttending physician or er evaluates the resident for | | | F758 The statements made on this plan of | | |

Facility ID: 953224

If continuation sheet Page 17 of 24

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | PRINTED: 01/15/2020 FORM APPROVED OMB NO. 0938-0391 |
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| STATEMENT O | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 345404 | B. WING | | C 12/12/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| | VERS HEALTH AND REI | | 1 | 1403 CONNER DRIVE | |
| | VERS HEALIN AND REI | | 1 | WINDSOR, NC 27983 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION |
| F 758 | Continued From page | e 17 | F 758 | | |
| | Continued From page 17 interviews, the facility failed to ensure a physician's order for as needed (PRN) psychotropic (drug that affects mental state) medication was time limited in duration for 2 of 6 residents reviewed for unnecessary medication (Resident #41 and #39). Findings included: Resident #41 was admitted to the facility on 9/30/19 with diagnoses that included congestive heart failure and anxiety disorder. The admission Minimum Data Set (MDS) assessment dated 10/07/19 indicated Resident #41 was cognitively intact and received an antianxiety medication 5 days during the look back period. A physician's order dated 10/04/19 indicated Xanax (antianxiety medication) 0.5 milligrams (mg) by mouth every 12 hours as needed for anxiety. There was no stop date written for the PRN Xanax order. | | | correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all feed and state regulations the facility has or will take the actions set forth in the plan of correction. The plan of correction. The plan of correction compliance such that all alleged deficiencies cited have been or will corrected by the dates indicated. Plan for correcting specific deficience process that led to deficiency cited. 1. A physician order dated 10/04, indicated that Xanax (antianxiety medication) 0.5 milligrams (mg) by every 12 hours as needed for anxie 01-03-2019, a physician order with date was obtained for Resident #41 2 A physician order dated 11/10/2 indicated that Xanax (an antianxiety medication) 0.5 milligrams (mg) by medicat | e deral staken nis ection f be //2019 //2019 mouth ty. On a stop . 2019 // |
| | 2019 to December 10 documentation on the had received 9 doses 3 doses in November | d (MAR) from October 4, 0, 2019 revealed per staff MARs that Resident #41 of PRN Xanax in October, r, and 4 doses in December | | every 6 hours as needed for anxiety 01-03-2019, a physician order with date was obtained for Resident #39 | y. On a stop |
| | regimen review for Rehad recommended the limit on 10/23/19 and response for the 10/2 review recommendat | macist (CP) #1 monthly drug esident #41 indicated the CP e physician clarify the time 11/22/19. The physician 3/19 monthly drug regimen ion was a handwritten note e stated the patient had | | A 100% audit on all current resident receiving PRN psychotropic medica to ensure stop dates were in place. audit was completed on 1-6-2019. concerns identified were corrected immediately. The Director of Nursing inserviced a | ations This Any |

Facility ID: 953224

If continuation sheet Page 18 of 24

| | | ND HUMAN SERVICES | | | | RM APPROVE 10. 0938-03 |
|--------------------------|-------------------------------|------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------|-------------|---------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | | E SURVEY IPLETED |
| | | 345404 | B. WING | | 1: | C 2/12/2019 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | Ē | |
| | | | | 1403 CONNER DRIVE | | |
| I HREE RI | VERS HEALTH AND REI | пав | | WINDSOR, NC 27983 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETIO DATE |
| F 758 | Continued From page | e 18 | F 75 | 8 | | |
| | | | 175 | | the | |
| | date. The physician r | es and did not include a stop esponse for the 11/22/19 n review recommendation for | | PT, and PRN RN's, LPN's, on following procedures: 01-09-2 | | |
| | | was a handwritten note | | Psychotropic Drugs- PRN ord | ers for | |
| | | n stated that Resident #41 | | psychotropic drugs are limited | | |
| | still required the Xana | ax since she had been on it | | and cannot be renewed unles | | |
| | long term and did not | t include a stop date. | | attending physician or prescri | | |
| | | | | practitioner evaluates the resi | | |
| | | #1 on 12/12/19 at 8:35 AM | | appropriateness of that medic | | |
| | | nt recommendations for the | | Any in-house staff member w | | |
| | | e number of days for the nd 11/22/19. She further | | receive in-service training by (will not be allowed to work un | | |
| | | vas provided for the 10/23/19 | | has been completed. This info | - | |
| | | I she had sent another | | been integrated into the stand | | |
| | | 11/22/19 and was unaware if | | orientation training and in the | | |
| | there had been a res | ponse and planned to follow | | in-service refresher courses for | - | |
| | | was in the facility. She | | employees and will be review | ed by the | |
| | further revealed it wa | s her normal practice to | | Quality Assurance process to | verify that | |
| | discuss with the Dire | ctor of Nursing (DON) or | | the change has been sustaine | ed. | |
| | | if she did not receive a | | | | |
| | | monthly drug regimen | | The monitoring procedure to e | | |
| | | d be December for Resident | | the plan of correction is effect | | |
| | #41. | | | specific deficiency cited remains | | |
| | An intonviow with Phy | version #1 on 12/12/10 at | | and/or in compliance with the requirements: | regulatory | |
| | • | /sician #1 on 12/12/19 at was aware of the Centers | | | | |
| | | dicare (CMS) regulation that | | The Director of Nursing or Su | oport Nurse | |
| | | otropic medication required | | will conduct audits to ensure F | - | |
| | | psychotropic medication | | for psychotropic drugs are lim | | |
| | | rescribed for Resident #41. | | days and cannot be renewed | | |
| | | ually good about review of | | attending physician or prescri | - | |
| | - | ns but had "just not gotten | | practitioner evaluates the resi | | |
| | around to looking at I | | | appropriateness of that medic | | |
| | providing a stop date | . | | These audits will be conducted | | |
| | An interview de la | Administrator or 10/10/10 | | two weeks and monthly for 3 i | | |
| | | Administrator on 12/12/19 at | | monitoring will continue until r | - | |
| | | e physician should provide a | | QOL/QA committee. Reports | | |
| | CMS regulations. | ychotropic medications per | | presented to the weekly QA control the Administrator or DON to e | - | |

Facility ID: 953224

If continuation sheet Page 19 of 24

| | | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPI | E CONSTRUCTION | (X3) DATE | 0. 0938-039 SURVEY |
|--------------------------|---------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | . , | | · · · | LETED |
| | | | | | | 2 |
| | | 345404 | B. WING | | 12/ | 12/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | : | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THREE RI | VERS HEALTH AND RE | НАВ | | 1403 CONNER DRIVE WINDSOR, NC 27983 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETIOI DATE |
| F 758 | Continued From pag | e 19 | F 758 | 3 | | |
| | Resident #39 was 11/4/19 with diagnos and diabetes. A physician 's order | admitted to the facility on es that included heart failure dated 11/10/19 indicated | | corrective action initiated as app Compliance will be monitored ar ongoing auditing program review weekly QA Meeting. The weekly Meeting is attended by the Admi | nd ved at the QA inistrator, | |
| | (mg) by mouth every anxiety. There was as needed Xanax or | | | DON, MDS Coordinator, Therap and the Dietary Manager. The title of the person responsib implementing the plan of correct The Administrator is responsible | le for ion. | |
| | #39 was cognitively i | 1/11/19 indicated Resident mpaired and received an | | implementation and completion acceptable plan of correction. | of the | |
| | antianxiety medication period. | on 1 day during the look back | | Date of Compliance: | | |
| | regimen review for R recommended the pl | macist (CP) monthly drug esident #39 indicated the CP hysician clarify the time limit anax order on 11/22/19. esponse. | | | | |
| | PM with Physician #2 aware the order for the ordered to be admini basis, should have h | nducted on 12/12/19 at 12:49 2 who indicated he was he Xanax, which was stered on an as needed ad a stop date and he would | | | | |
| | stop date. He contir daily and only had a | contact him regarding the nued he was not at the facility few residents as patients. Administrator on 12/12/19 at | | | | |
| | 11:01 AM revealed th stop date when writir psychotropic medica | ne physician should provide a ng orders for as needed tions. | _ | | | |
| F 761 SS=D | Label/Store Drugs ar CFR(s): 483.45(g)(h) | - | F 761 | | | 1/9/20 |

Facility ID: 953224

If continuation sheet Page 20 of 24

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | | RINTED: 01/15/2020 FORM APPROVED //B NO. 0938-039 | |
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| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 345404 | B. WING | | | | C 12/12/2019 | |
| NAME OF PF | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THREE RI | VERS HEALTH AND REP | IAB | | | 1403 CONNER DRIVE WINDSOR, NC 27983 | | | |
| (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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 761 | Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h)(1) In acco Federal laws, the faci biologicals in locked of temperature controls, personnel to have acco §483.45(h)(2) The face locked, permanently a storage of controlled the Comprehensive E Control Act of 1976 a abuse, except when the package drug distribu- quantity stored is min be readily detected. This REQUIREMENT by: Based on observation facility failed to discar of 2 medication room Findings included: 1. On 12/10/19 at 1:3 | of Drugs and Biologicals a used in the facility must be with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can f is not met as evidenced and staff interviews, the d expired medications in 2 | F | 761 | | o and do the federal nas taker | | |
| | were found in the me These 2 open vials of | protein derivative (PPD) dication room refrigerator. PPD had 1 vial which was vial which was undated. | | | plan of correction. The plan of co constitutes the facility's allegation compliance such that all alleged deficiencies cited have been or w | n of | | |

Facility ID: 953224

If continuation sheet Page 21 of 24

| | - | ND HUMAN SERVICES MEDICAID SERVICES | | | FOR | D: 01/15/202 MAPPROVEI O. 0938-039 |
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| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | | E SURVEY IPLETED |
| | | 345404 | B. WING | | 12 | C 2/ 12/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THREE RI | VERS HEALTH AND REI | НАВ | | 403 CONNER DRIVE | | |
| | | | V | WINDSOR, NC 27983 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION Y MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY) | | SHOULD BE | (X5) COMPLETION DATE | |
| F 761 | Continued From page | e 21 | F 761 | | | |
| | | | | corrected by the dates indicate | d. | |
| | An interview on 12/10 | 0/19 at 1:44 PM with Nurse | | , , | | |
| | | n vials should have been | | | | |
| | | had been open more than 30 | | Plan for correcting specific defi | • | |
| | days and the other or | ld be dated when opened | | process that led to deficiency of | lited. | |
| | | fter being open 30 days. | | 1. On 12/10/2019, in the long | a term care | |
| | | | | medication storage room, 2 op | | |
| | | 0/19 at 1:52 PM with the | | PPD (1 vial which was dated 1 | 0/25/19 and | |
| | | DON) indicated both open | | 1 vial was undated) were disca | arded by the | |
| | | e been discarded and | | Director of Nursing. | - 1- | |
| | | n available for resident use. PD should be dated when | | 2 On 12/10/2019, in the reha medication room, 2 open vials | | |
| | | d 30 days after opened per | | dated were discarded by the D | | |
| | manufacturer recomm | | | Nursing. | | |
| | | 1/19 at 3:08 PM with the | | A 100% audit of medications st | - | |
| | | ed expired medications | | rooms was conducted to ensur | • | |
| | | the facility should follow nendations and should not | | and biologicals used in the faci labeled and dated according to | | |
| | be available for resid | | | regulation. This was complete | | |
| | | | | Director of Nursing on 01-03-20 | | |
| | 2. On 12/10/19 at 2:1 | 5 PM during the | | | | |
| | rehabilitation medicat | 0 | | On 12/31/19, The Director of N | | |
| | | undated vials of purified | | began in servicing all FT, PT, a | | |
| | | PD) were found in the | | RN's, LPN's, on the following p | procedures: | |
| | of PPD were undated | igerator. These 2 open vials | | Label/Store Drugs and Biologic | als | |
| | | a. | | CFR(s): 483.45(g)(h)(1)(2)483. | | |
| | An interview on 12/10 | 0/19 at 2:22 PM with Nurse | | Labeling of Drugs and Biologic | | |
| | #5 indicated that both | n vials should have been | | and biologicals used in the faci | ility must be | |
| | discarded. | | | labeled in accordance with cur | • | |
| | | | | accepted professional principle | | |
| | | 0/19 at 1:52 PM with the DON) indicated both open | | include the appropriate access cautionary instructions, and the | • | |
| | | ve been discarded and | | date when applicable.483.45(h | | |
| | | available for resident use. | | of Drugs and Biologicals483.45 | , . | |
| | | PD should be dated when | | accordance with State and Fed | | |
| | | d 30 days after opened per | | the facility must store all drugs | | |

Facility ID: 953224

If continuation sheet Page 22 of 24

| | | ND HUMAN SERVICES MEDICAID SERVICES | | | F | NTED: 01/15/2020 ORM APPROVED 3 NO. 0938-0391 |
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| STATEMENT (| DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | DATE SURVEY COMPLETED |
| | | 345404 | B. WING _ | | | C 12/12/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STAT | E, ZIP CODE | |
| | | | | 1403 CONNER DRIVE | | |
| | VERS HEALTH AND REI | пав | | WINDSOR, NC 27983 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | X (EACH CORRECT CROSS-REFERENC | LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY) | (X5) COMPLETION DATE |
| F 761 | F 761 Continued From page 22 manufacturer recommendations. An interview on 12/11/19 at 3:08 PM with the Administrator revealed expired medications should be discarded, the facility should follow manufacturer recommendations and should not be available for resident use. | | F | proper temperature of only authorized perso to thekeys.483.45(h) provide separately lo affixed compartments controlled drugs liste the Comprehensive I Prevention and Cont other drugs subject to | onnel to have access (2) The facility must ocked, permanently s for storage of ed in Schedule II of Drug Abuse rol Act of 1976 and o abuse, except s single unit package tems in which the | |
| | | | | dose can be readily of Any in-house staff m receive in-service tra will not be allowed to | detected. ember who did not aining by 1-9-2019, work until training . This information has the standard nd in the required courses for all be reviewed by the rocess to verify that | |
| | | | | specific deficiency ci and/or in compliance requirements: The Director of Nursi | n is effective and that ted remains corrected with the regulatory ing or Support Nurse | |
| | | | S11 | | in the facility are ccording to the conducted weekly for hly for 3 months. This | |

Event ID:0RLS11

Facility ID: 953224

If continuation sheet Page 23 of 24

| DEPART | MENT OF HEALTH AN | ID HUMAN SERVICES | | | | | 1 APPROVED | | |
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| | | MEDICAID SERVICES | | | | OMB NO. 0938-0391 | | | |
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
| | | | A. BUILDI | NG_ | | | C | | |
| | | 345404 | B. WING | | | 12/12/2019 | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | • | | | |
| THREE R | VERS HEALTH AND REF | IAB | | 1403 CONNER DRIVE | | | | | |
| | · _ · · · · · · · · · · · · · · · · · · | | | N | /INDSOR, NC 27983 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | | |
| F 761 | Continued From page | 23 23 | F | 761 | QOL/QA committee. Reports will be presented to the weekly QA committee the Administrator or DON to ensure corrective action initiated as appropriat Compliance will be monitored and ongoing auditing program reviewed at weekly QA Meeting. The weekly QA Meeting is attended by the Administrat DON, MDS Coordinator, Therapy, HIM and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction. Date of Compliance: 01/09/2020 | the or, | | | |

Facility ID: 953224

If continuation sheet Page 24 of 24