C C Date of PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P COCE MARKE OF PROVIDERS AND REHABILITATION CENTER Date NULSING AND REHABILITATION CENTER Colspan="2">Date NULSING NULSING NUTSING NULSING NULSI		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY PLETED
NUMBLE OF PROVIDER OR SUPPLIER UNITED DAVIE NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE DAVIE NURSING AND REHABILITATION CENTER DEVICE STREET ADDRESS, CITY, STATE, ZIP CODE DAVIE NURSING AND REHABILITATION CENTER DEVICE STREET ADDRESS, CITY, STATE, ZIP CODE DAVIE NURSING AND REHABILITATION CENTER DEVICES STREET ADDRESS, CITY, STATE, ZIP CODE DAVIE NURSING AND REHABILITATION CENTER DEVICES STREET ADDRESS, CITY, STATE, ZIP CODE DAVIE NURSING AND REHABILITATION CENTER DEVICES STREET ADDRESS, CITY, STATE, ZIP CODE DAVIE NURSING AND REHABILITATION CENTER DEVICES STREET ADDRESS, CITY, STATE, ZIP CODE DAVIE NURSING AND REHABILITATION CENTER DEVICES STREET ADDRESS, CITY, STATE, ZIP CODE DAVIE NURSING AND REHABILITATION CENTER DEVICE STREET ADDRESS, CITY, STATE, ZIP CODE E 000 Initial Comments E 000 An unannounced recertification survey was conducted during a recertification survey transmithere and survices that are included in nursin	345129 NAME OF PROVIDER OR SUPPLIER				_		
DAVIE NURSING AND REHABILITATION CENTER DOCKSVILLE, NC 27024 MOLING ISLAMARY STATEMENT OF DEFICIENCIES PROVIDERS FLAM CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) 000000000000000000000000000000000000				TREET ADDRESS, CITY, STATE, ZIP CODE	02/	13/2020	
Deckevenue Deckevenue <thdeckevenue< th=""> Deckevenue Deckeven</thdeckevenue<>	DAVIE NU	RSING AND REHABILIT	ATION CENTER				
Prefry TAG REGULTORY OR LSC DEMTRYING NFORMATION PREFX TAG CROSS-REFERENCED To THE ACTION SHOULD BE CROSS-REFERENCED TO THE APPORPTIATE DEFICIENCY COMPLET DEFICIENCY E 000 Initial Comments E 000 E 000 An unannounced recertification survey was conducted on 2/9/2020 through 2/13/2020. The facility was found in complaint investigation survey preparedness. Event ID# K16811. F 000 F 000 F 000 An unannounced complaint investigation survey was conducted during a recertification survey from 2/9/20 through 2/13/20. Five of five allegations investigated were unsubstantiated. The 2567 was amended to correct residents' identification numbers in tag F362. F 000 F 582 S=6 CFR(s). 483.10(g)(17)(17)(10)(-v) S483.10(g)(17)(17)(17)(10)(-v) F 582 S=6 CFR(s). 483.10(g)(17)(17)(10)(-v) S483.10(g)(17)(17)(17)(10)(-v) F 582 S=6 CFR(s). 483.10(g)(17)(17)(10)(-v) S483.10(g)(17)(17)(17)(10)(-v) F 582 S=6 CFR(s). 483.10(g)(17)(17)(10)(-v) S483.10(g)(17)(17)(10)(-v) S 586 CFR(s). 483.10(g)(17)(17)(10)(-v) S 586 CFR(s). 483.10(g)(17)(17)(0)(-v) S 586 CFR(s). 483.10(g)(17)(17)(A)(A) S 586			-	N	MOCKSVILLE, NC 27028		
An unannounced recettification survey was conducted on 2/9/2020 through 2/13/2020. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# K16811. F 000 F 000 INITIAL COMMENTS F 000 An unannounced complaint investigation survey was conducted during a recetification survey from 2/9/20 through 2/13/20. Five of five allegations investigated were unsubstantiated. The 2567 was amended to correct residents' identification numbers in tag F582. F 582 F 582 Medicaid/Medicare Coverage/Liability Notice SS=8 F 582 CFR(s): 483.10(g)(17)(18)(i)-(v) F 582 \$483.10(g)(17) The facility must- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (ii) Inform each Medicaid-eligible resident, in writing, at the issident becomes eligible for Medicaid of- (A) The items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in \$483.10(g)(17)(1)(A) and (B) of this section. \$483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident stay, of services available in the facility and of charges for those earlies are made to the items and services specified in \$483.10(g)(17)(1)(A) and (B) of this section.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	COMPLETIO
conducted on 2/9/2020 through 2/13/2020. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# K16811. F 000 F 000 INITIAL COMMENTS F 000 An unannounced complaint investigation survey was conducted during a recertification survey from 2/9/20 through 2/13/20. The of five allegations investigated were unsubstantiated. The 2567 was amended to correct residents' identification numbers in lag F582. F 000 F 582 Medicaid/Medicare Coverage/Liability Notice SS=B CFR(s): 483.10(g)(17)(18)(i)-(v) SS=B CFR(s): example. Liability must(i) Inform each Medicaid-eligible resident may be charged, and the amount of charges for those services; and Side 10 for meach Medicaid-eligible resident when changes are made to the items and services that are included in nursing facility resident may not be charged, (B) Those other litems and services that previde the state plan and for which the resident may be charged, and the amount of charges for those services; and III form each Medicaid-eligible resident when changes are made to the items and services that the facility offers and for which the resident may be charged, expense and the or which the resident when changes are made to the items and services are made to the items and services are made to the items and services are made to the item of admission, and periodically during the resident's services are are as and to charges for those available in the facility and of charges for those available in the facility and of charges for those TIME VMIME	E 000	Initial Comments		E 000			
An unannounced complaint investigation survey was conducted during a recertification survey from 2/9/20 through 2/13/20. Five of five allegations investigated were unsubstantiated. The 2567 was amended to correct residents' identification numbers in tag F582. F 582 Medicald/Medicare Coverage/Liability Notice SS=B F 582 F 582 Medicald/Medicare Coverage/Liability Notice Coverage/Liability Notice SS=B F 582 CFR(s): 483.10(g)(17) The facility must(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility services under the State plan and for which the resident becomes eligible for Medicaid of-(A) The items and services that are included in nursing facility services under the State plan and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in \$483.10(g)(17)(i)(A) and (B) of this section. \$483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those tott 1000000000000000000000000000000000000		conducted on 2/9/202 facility was found in c requirement CFR 483	20 through 2/13/2020. The compliance with the 3.73, Emergency				
was conducted during a recertification survey from 20/20 through 21/3/20. Five of five allegations investigated were unsubstantiated. The 2567 was amended to correct residents' identification numbers in tag F582. F 582 Selection 1000000000000000000000000000000000000	F 000	INITIAL COMMENTS	i	F 000			
F 582 SS=B Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) F 582 3/4/20 §483.10(g)(17) The facility must (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. F 582 THE (#) PATE		was conducted during from 2/9/20 through 2 allegations investigat The 2567 was amend	g a recertification survey 2/13/20. Five of five ed were unsubstantiated. ded to correct residents'				
(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- Image: Comparison of the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; Image: Comparison of the time and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and Image: Comparison of the times and services services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in \$483.10(g)(17)(i)(A) and (B) of this section. Stats.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those Image: Comparison of the time of admission, and periodically during the resident's stay. SORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Image: Comparison of the time of admission adm		Medicaid/Medicare C	overage/Liability Notice	F 582			3/4/20
resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		 (i) Inform each Medic writing, at the time of facility and when the Medicaid of- (A) The items and se nursing facility service for which the resident (B) Those other items facility offers and for charged, and the amo services; and (ii) Inform each Medic changes are made to specified in §483.10(9) 	aid-eligible resident, in admission to the nursing resident becomes eligible for rvices that are included in es under the State plan and t may not be charged; s and services that the which the resident may be bount of charges for those caid-eligible resident when the items and services				
		resident before, or at periodically during the	the time of admission, and e resident's stay, of services				
Electronically Signed 03/04/20			SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE 03/04/202

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.

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/13/202 FORM APPROVE OMB NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345129	B. WING		C 02/13/2020
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DAVIE NU	RSING AND REHABILIT	ATION CENTER		98 MADISON ROAD OCKSVILLE, NC 27028	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	LIST MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 582	Continued From pag	e 1	F 582		
	services, including a	ny charges for services not care/ Medicaid or by the			
	facility's per diem rat				
	(i) Where changes in	coverage are made to items			
		d by Medicare and/or by the			
		the facility must provide			
	reasonably possible.	f the change as soon as is			
		re made to charges for other			
		nat the facility offers, the			
		ne resident in writing at least			
		ementation of the change.			
		or is hospitalized or is not return to the facility, the			
		the resident, resident			
	-	tate, as applicable, any			
		lready paid, less the facility's			
		e days the resident actually			
		or retained a bed in the			
	discharge notice requ	any minimum stay or			
		refund to the resident or			
		ve any and all refunds due			
) days from the resident's			
	date of discharge fro	-			
		ndmission contract by or on al seeking admission to the			
		lict with the requirements of			
	these regulations.				
	-	T is not met as evidenced			
	by:				
		view and medical record		Preparation and submission of this P	lan
		iled to provide a CMS-10055		of Correction does not constitute an	
		e and Medicaid Services) ity Advanced Beneficiary		admission of or agreement with, it is required by State and Federal law. It	is
		rior to discharge from		executed and implemented as a mean	
	, , , , ,	ed services to two of four		continuously improve the quality of ca	
		#36 and Resident #183)		comply with State and Federal	
	reviewed for SNF Be	neficiary Protection		requirements.	

Facility ID: 922953

		ND HUMAN SERVICES				FOR	D: 03/13/20 MAPPROV 0. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345129	B. WING			02	C 2/13/2020
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
DAVIE NU	RSING AND REHABILIT	ATION CENTER			8 MADISON ROAD		
_				M	OCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 582	Continued From pag	e 2	F 58	82			
	Notification.			-			
					Resident #36'⊡s responsible party w	as	
	Findings included:				educated on resident rights including		
	_				liability notice. Resident #183 is no	onger	
		admitted on 08/21/19 and			in facility. Neither resident had any		
	currently resided in the	he facility during the review.			negative outcome as a result of this		
	A review of the SNE	Beneficiary Protection			To identify other residents who have potential to be affected, all residents		
		or Resident #36 revealed			experienced a discontinuation of skil		
		ed service start date was			service coverage since 2/1/2020 we		
		on 09/03/19. The services			reviewed by the facility business official		
	were terminated bec	ause Resident #36 had			manager and administrator, to ensur		
		practical level according to			they were given an Advanced Benef	iciary	
		10055 was not provided to			Notice (ABN) and this was properly		
	Resident #36 or their	r Responsible Party (RP).			documented. Any residents identified negative outcomes will have resident		
		on 02/12/20 at 3:28 PM, the			rights education provided.		
		ager (BOM) confirmed she			Resident rights were also reviewed	with	
		NF/ABN, form CMS-10055			resident council on 2/27/2020.		
		the resident's RP. Her n to issue the form was if the			To prevent this from recurring, the business office manager, and social		
		ntinue with therapy services			worker were educated by the Corpor		
		ed then she provided a			Director of Social Services and Activ		
		S-10055. If the resident			on the process for providing residen		
	chose not to continue	e with therapy services, she			responsible parties an ABN and		
		IS-10123 form. The BOM			documentation of providing the ABN	on	
		both forms would be			2/27/2020.		
	1	s who remained in the facility			Once a discharge date is determined		
		services were to continue			business office manager will notify the		
	responsible.	pay making the resident			facility social worker. The facility soc worker or designee, then issues the		
					to the resident or responsible party a		
	During an interview o	on 02/13/19 at 3:07 PM, the			completes documentation in the reco		
		stood that both forms needed			To monitor and maintain ongoing		
		resident or the resident's			compliance, facility administrator will	audit	
	responsible party. H				three residents per week who had a		
		M did not know this and that			discontinuation of skilled services, for		
		ould make sure it was clear			weeks, to ensure ABNs were provide		
	that when a resident	remained in the facility and			timely and documented beginning th	е	

Facility ID: 922953

If continuation sheet Page 3 of 31

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	A. BUILDING		
				C		
	345129		B. WING		02/13/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
DAVIE NU	RSING AND REHABILIT	ATION CENTER		498 MADISON ROAD MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLE THE APPROPRIATE DATE	
F 582	Continued From page	e 3	F 58	32		
		Medicare Part A services		week of 2/28/2020.		
		both the CMS-10055 and		The results of the audits v		
	CMS-10123 forms we resident or their RP.	ere provided to either the		to the facility QAPI commi review and recommendat		
				duration of the auditing.		
		s admitted on 09/11/19 and		Administrator is responsib	le for	
	was not residing in th	e facility during the review.		compliance.		
	A review of the SNF I	Beneficiary Protection				
		or Resident #183 revealed				
		ed service start date was				
		on 09/24/19. The services ause Resident #183 had				
		practical level according to				
		10055 was not provided to				
	Resident #183 or the	ir Responsible Party (RP).				
	During an interview o	n 02/12/20 at 3:28 PM, the				
		ager (BOM) confirmed she				
		NF/ABN, form CMS-10055 he resident's RP. Her				
		to issue the form was if the				
		itinue with therapy services				
	after being discharge	d then she provided a				
		-10055. If the resident				
		e with therapy services, she IS-10123 form. The BOM				
	stated going forward					
		s who remained in the facility				
		ervices were to continue				
		pay making the resident				
	responsible.					
		n 02/13/19 at 3:07 PM, the				
		tood that both forms needed				
	-	resident or the resident's				
	responsible party. He unaware that the BOI	M did not know this and that				
		uld make sure it was clear				

Facility ID: 922953

If continuation sheet Page 4 of 31

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/13/202 FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129		(X1) PROVIDER/SUPPLIER/CLIA	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		B. WING		C 02/13/2020	
NAME OF PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD		
DAVIE NU	RSING AND REHABILIT	ATION CENTER		498 MADISON ROAD MOCKSVILLE, NC 27028	
(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 COMPLÉTIO
F 582	was discharged from with remaining days I	e 4 remained in the facility and Medicare Part A services both the CMS-10055 and ere provided to either the	F 582	2	
F 623 SS=B		Before Transfer/Discharge -(6)(8)	F 623	3	3/4/20
	the reasons for the m language and manne facility must send a c representative of the Long-Term Care Oml (ii) Record the reason discharge in the resic accordance with para and (iii) Include in the not paragraph (c)(5) of the §483.15(c)(4) Timing	fers or discharges a nust- and the resident's he transfer or discharge and nove in writing and in a er they understand. The opy of the notice to a Office of the State oudsman. ns for the transfer or dent's medical record in agraph (c)(2) of this section; ice the items described in nis section.			
	 (i) Except as specified (c)(8) of this section, discharge required un made by the facility a resident is transferred (ii) Notice must be ma before transfer or dist (A) The safety of individue endangered under this section; (B) The health of individual 	d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be it least 30 days before the d or discharged. ade as soon as practicable			

If continuation sheet Page 5 of 31

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/13/2020 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	345129		B. WING				C / 13/2020
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
DAVIE NU	RSING AND REHABILIT	ATION CENTER		4	498 MADISON ROAD		
				Ν	MOCKSVILLE, NC 27028		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	this section; (C) The resident's he allow a more immedia under paragraph (c)((D) An immediate tra required by the reside under paragraph (c)((E) A resident has no days. §483.15(c)(5) Conter notice specified in pa must include the follo (i) The reason for tra (ii) The effective date (iii) The location to wit transferred or dischal (iv) A statement of the including the name, a and telephone number to obtain an appeal for completing the form a hearing request; (v) The name, addrest telephone number of Long-Term Care Oml (vi) For nursing facilit and developmental d disabilities, the mailin telephone number of the protection and ad developmental disabi C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilit	ealth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; nsfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or at resided in the facility for 30 hts of the notice. The written tragraph (c)(3) of this section owing: unsfer or discharge; of transfer or discharge; hich the resident is rged; e resident's appeal rights, address (mailing and email), er of the entity which sts; and information on how form and assistance in and submitting the appeal ess (mailing and email) and the Office of the State budsman; y residents with intellectual isabilities or related ng and email address and the agency responsible for lvocacy of individuals with ilities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402,	F	623			

Facility ID: 922953

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/13/20 FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
	345129		B. WING		02/13/2020
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
DAVIE NU	RSING AND REHABILIT	ATION CENTER		498 MADISON ROAD	
	1			MOCKSVILLE, NC 27028	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 623	Continued From page	e 6	F 623		
1 025		e o lephone number of the	F 023		
	agency responsible f	•			
		als with a mental disorder			
		e Protection and Advocacy			
	§483.15(c)(6) Chang				
		he notice changes prior to			
		or discharge, the facility			
		pients of the notice as soon he updated information			
	becomes available.	ne updated information			
	\$483 15(c)(8) Notico	in advance of facility closure			
		closure, the individual who is			
	-	he facility must provide			
		ior to the impending closure			
		gency, the Office of the			
	State Long-Term Car	e Ombudsman, residents of			
	-	esident representatives, as			
		ne transfer and adequate			
		dents, as required at §			
	483.70(I).	L is not mot as suideneed			
	by:	Γ is not met as evidenced			
		esident representative and		Resident #19 and resident #59 v	vere
		ecord review, the facility		admitted back to facility prior to s	
	failed to provide the r	-		exit of 2/13/2020. Both residents	-
	representative a writt	en notification for the reason		education of the requirement of	
		spital for 2 of 3 residents		transfer/discharge notifications.	
		esident #59) reviewed for		resident had any negative outcom	nes from
	hospitalization.			this event.	41
	Eindings included:			To identify other residents who ha	
	Findings included:			potential to be affected, the facilit administrator completed an audit	
	1. Resident #19 was	admitted to the facility on		residents currently in the hospital	
		es that included, in part,		2/13/2020, in order to ensure res	
	diabetes and hyperte	-		had received the proper	
				transfer/discharge notifications.	There

Event ID: K16811

Facility ID: 922953

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/13/2 FORM APPROV OMB NO. 0938-03
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345129	B. WING	C 02/13/2020	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
DAVIE NU	RSING AND REHABILIT	ATION CENTER		498 MADISON ROAD MOCKSVILLE, NC 27028	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETI
F 623	The comprehensive r assessment dated 12 #19 was cognitively in The medical record in representative was a A nurse's note in the Resident #19 was tra 1/21/20 due to low he note indicated Reside notified of the transfe resident was re-admi No written notice of th have been provided t representative. On 2/10/20 at 9:59 A completed with Reside approximately three w to the hospital becaus recalled she had not transfer/discharge fro to the hospital. During an interview w representative on 2/1 expressed he was not 1/21/20 when Reside hospital but had not r transfer/discharge. On 2/11/20 at 1:23 PI Nurse #1, who was o was sent to the hospi Nurse #1 but the pho An interview was com	minimum data set 2/12/19 revealed Resident ntact. Indicated Resident #19's family member. Immedical record reported insferred to the hospital on emoglobin and bleeding. The ent #19's representative was r to the hospital. The tted to the facility on 1/26/20. ransfer was documented to o the resident or resident M an interview was lent #19. She stated weeks earlier she transferred se "I was bleeding." She received a written notice of om the facility when she went with Resident #19's	F 62		red at re bocial rporate Activities ice of nd proper ducation y the s, to ntaining . The ted to n will be s and any ffice ing a ice of rss Office nt or t dut three (s, to er / 0. Any ed. These n audit forwarded r further

Facility ID: 922953

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		MEDICAID SERVICES	(X2) MULT	PLF	CONSTRUCTION	(X3) DATE	D. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	` <i>`</i>			· /	PLETED
						С	
345129		B. WING			02/	13/2020	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DAVIE NU	RSING AND REHABILIT	ATION CENTER			8 MADISON ROAD OCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 623	Continued From page	2.8	F 6	22			
1 020	- 15	tice when a resident was	ΓŬ	23	Administrator is responsible for compliance.		
	at 4:10 PM. She exp educated in their initia needed to be sent wh hospital. She said the included a facesheet, medication administra order to transport to t bed hold policy. Nurs transfer/discharge no resident when transfer During an interview w Nursing on 2/12/20 at nurses typically had r transfer/discharge wh hospital and added st	al training about what forms hen a resident went to the e forms that were sent discharge summary, ation record, the physician's he hospital, code status and se Supervisor #1 stated the tice was not sent with the erred to the hospital. With the Assistant Director of t 3:08 PM she revealed the hot sent a written notice of hen a resident went to the he was unsure who was he notice sent to the resident					
	She recalled Residen hospital on 1/21/20 for hemoglobin. She rep at the nurse's station needed to be sent wh hospital. She added the written notice of the	irector of Nursing (DON). It #19 was transferred to the or bleeding and low borted there was a check list of the paperwork that hen a resident went to the she was unsure who sent ransfer/discharge to the representative when a					
	Supervisor #1 on 2/1	vas provided by Nurse 1/20 at 4:30 PM. The tice was not a form that was list					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/13/2020 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
				_		С	
		345129	B. WING			02/	13/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
DAVIE NU	RSING AND REHABILITA	ATION CENTER			198 MADISON ROAD		
				Ν	MOCKSVILLE, NC 27028		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	Y	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
F 623	Continued From page	<u> </u>		~~~			
1 025	Continued From page	:9		623			
	On 2/13/20 at 10:33 A	AM an interview with the					
		d that the transfer/discharge					
		to be completed by the e resident prior to being					
		pital. He acknowledged the					
		sistently being followed by					
	-	had just been re-educated					
	about the process.						
	2. Resident #59 was a	admitted to the facility on					
		es that included, in part,					
	heart failure and hype	ertension.					
	The comprehensive n	ninimum data set					
		19/20 revealed Resident #59					
	had cognitive impairm	nent.					
	The medical record in	dicated Resident #59's					
	representative was a						
		medical record reported					
		nsferred to the hospital on					
		ness of breath, abnormal oxygen levels. The medical					
		no evidence that a written					
	notice of transfer/disc	harge was provided to the					
		representative when she					
	was transferred to the	e nospital.					
	Resident #59 was rea	admitted to the facility from					
		treatment for aspiration					
	pneumonia on 10/18/	19.					
	On 2/13/20 at 1:56 PM	M an interview was					
		usiness Office Manager					
	(BOM). The BOM ad	ded she typically called a					
	resident's representat	tive and remembered calling					

Facility ID: 922953

If continuation sheet Page 10 of 31

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/13/2020	
		345129	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DAVIE NU	RSING AND REHABILITA	ATION CENTER			98 MADISON ROAD IOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Resident #59's repress discharge to the hosp the resident represen regarding the residen facility. She stated th Administrative Assista certified letter to the re- the discharge. The B letter signature receip one for Resident #59' On 2/13/20 at 2:12 Pl Resident #59's repress was obtained. During an interview w Nursing on 2/12/20 at nurses typically had n transfer/discharge wh hospital and added sh responsible to have th and resident represen On 2/12/20 at 3:01 Pl completed with the Di She reported there was station of the paperwo when a resident went she was unsure who transfer/discharge to representative when a hospital. Review of the transfer 4:30 PM revealed tha notice was not a form check list.	sentative to notify her of the nital. The facility also sent tative a certified letter t's discharge from the at she would notify the ant, who would then send a esident representative about OM reviewed the certified ots and stated there was not is representative. M a phone call was placed to sentative but no interview with the Assistant Director of a 3:08 PM she revealed the not sent a written notice of then a resident went to the ne was unsure who was ne notice sent to the resident native.	F	623			

		ID HUMAN SERVICES			PRINTED: 03/13/202 FORM APPROVEI
STATEMENT (S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	345129		B. WING		C 02/13/2020
NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CO	
	RSING AND REHABILIT		498	MADISON ROAD	
			MO	CKSVILLE, NC 27028	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE
F 623 F 625 SS=B	notice was supposed nurse and given to the transferred to the hos process was not cons nursing staff and staff about the process. Notice of Bed Hold Pe CFR(s): 483.15(d)(1) §483.15(d) Notice of I §483.15(d)(1) Notice nursing facility transfe the resident goes on the nursing facility must p the resident or reside specifies- (i) The duration of the any, during which the return and resume rest facility; (ii) The reserve bed p plan, under § 447.40 (iii) The nursing facility bed-hold periods, whit paragraph (e)(1) of the resident to return; and (iv) The information s of this section.	e that the transfer/discharge to be completed by the e resident prior to being spital. He acknowledged the sistently being followed by f had just been re-educated olicy Before/Upon Trnsfr (2) bed-hold policy and return- before transfer. Before a ers a resident to a hospital or therapeutic leave, the provide written information to nt representative that e state bed-hold policy, if e resident is permitted to sidence in the nursing payment policy in the state of this chapter, if any; ty's policies regarding ich must be consistent with his section, permitting a d pecified in paragraph (e)(1)	F 623		3/4/20
	the time of transfer of hospitalization or ther facility must provide to resident representation specifies the duration	old notice upon transfer. At a resident for rapeutic leave, a nursing o the resident and the ve written notice which of the bed-hold policy oh (d)(1) of this section.			

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•=		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · · ·	ATE SURVEY
			A. BUILDING	<u> </u>		C
		345129	B. WING			02/13/2020
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	02/10/2020
				498 MADISON ROAD		
DAVIE NU	RSING AND REHABILIT	ATION CENTER		MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 625	Continued From pag	e 12	F 62	5		
		T is not met as evidenced	1 02			
	by:					
	•	esident representative and		Resident #19 and resident	#59 were	
		record review, the facility		admitted back to facility prio	r to survey	
	failed to provide the	resident and resident		exit of 2/13/2020. Both resid		
		ten notification of the bed		education of the facility bed		
		sident's transfer to the		and requirement of notificati		
		sidents (Resident #19 and		resident had any negative o	utcome from	
1	Resident #59) review	ved for hospitalization.		this event.		
	-			To identify other residents w		
	Findings included:			potential to be affected, the	•	
	1 Posidont #10 was	admitted to the facility on		administrator completed an residents currently in the ho		
		es that included, in part,		2/13/2020, in order to ensur		
	diabetes and hyperte			had received the proper bec		
				notifications and proper doc		
	The comprehensive	minimum data set		present in the record. There		
		2/12/19 revealed Resident		residents in the hospital as o		
	#19 was cognitively i			Resident rights were also re	viewed at	
				resident council on 2/27/202	20.	
		ndicated Resident #19's		To prevent this from recurrin	-	
	representative was a	family member.		Business Office Manager ar		
				Worker were educated by th		
		medical record reported		Director of Social Services a		
		ansferred to the hospital on		on the process for providing		
		emoglobin and bleeding. The the facility on 1/26/20. The		Policy and proper document 2/27/2020. Education was		
		onstrated no evidence that a		02-28-2020 by the Director	•	
		bed hold policy was provided		the nurses, to provide the di	•	
		esident representative when		packet containing the facility		
	she was transferred	•		policy. This education will b		
		·		any new hired nurses and a	•	
	On 2/10/20 at 9:59 A	M an interview was		nurses. The Business Office		
	completed with Resid	dent #19. She stated		responsible for sending a ce		
		weeks earlier she transferred		containing the Bed Hold Pol	-	
		se "I was bleeding." She		Business Office Manager wi		
		been contacted by anyone at		resident or responsible party		
	the facility about bed	hold after she transferred to		next business day to ensure	e that this	

Facility ID: 922953

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	COMPLETED
		345129	B WING		С
	ROVIDER OR SUPPLIER	545129		STREET ADDRESS, CITY, STATE, ZI	02/13/2020
				498 MADISON ROAD	
DAVIE NU	RSING AND REHABILIT	ATION CENTER		MOCKSVILLE, NC 27028	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETI O THE APPROPRIATE DATE
F 625	Continued From pag	e 13	F 62	25	
	bed hold policy.			To monitor and maintain	onaoina
				compliance, Administrate	or will audit three
	During an interview v			discharges per week for	
	representative on 2/1 expressed he had no	12/20 at 1:50 PM he of received a copy of the bed		ensure that the Bed Hold and properly documented	5
		sident #19 discharged to the		2/28/2020.	a sognining
	hospital.	-		The results of the audits	
	On 2/11/20 at 1:02 D	M a shasa adliwaa shaaadta		to the facility QAPI comm	
		M a phone call was placed to on duty when Resident #19		review and recommenda duration of the auditing.	itions for the
		ital. A message was left for		Administrator is responsi	ible for
	Nurse #1 but the pho	one call was not returned.		compliance.	
	An interview was cor	npleted with the Admissions			
	Coordinator on 2/11/2	20 at 9:44 AM during which			
		's bed hold policy was given			
		upon admission to the nursing department sent the			
		the resident when being			
	transferred to the hos	spital. The Admissions			
		the bed hold policy was not			
	sent by nursing she t	hought the business office			
	On 2/11/20 at 3:22 P	M on interview was			
		usiness Office Manager			
		d the bed hold policy was			
		when transferred to the			
		added she typically called a itive the day after being			
	· ·	spital and inquired if the			
	representative wante	d to do a bed hold. The			
		resident representative a			
		cluded a copy of the bed hold pressed she thought she had			
		s representative after she			
		spital and asked if he wanted			
	to hold Resident #19	'a had			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			PLETED
		345129	B. WING				C / 13/2020
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	10/2020
DAVIE NU	RSING AND REHABILIT	ATION CENTER			498 MADISON ROAD		
	1			ľ	MOCKSVILLE, NC 27028		1
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	During interviews with Assistant on 2/11/20 a indicated the BOM us resident went to the h immediately sent a cor representative that co She explained she ke that was signed by th when the letter was re Assistant reviewed th receipts and stated th Resident #19's represe may not have been m Resident #19 went to hold policy must have The Director of Nursin 2/12/20 at 3:01 PM. S resident transferred to bed hold policy was s the packet of informat resident to the hospita On 2/13/20 at 10:33 A Administrator reveale was to be sent with th the hospital and a cop representative in the process was not cons staff had just been re- process.	 a the Administrative at 3:33 PM and 4:20 PM she shally notified her when a pospital and then she ertified letter to the resident portained the bed hold policy. See the certified letter receipt the resident representative eccived. The Administrative eccived. The Administrative eccived on the Administrative eccived and so the bed so the hospital and so the bed and been sent. and was interviewed on She explained that when a pospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the hospital a copy of the apposed to be included in the al. 	F	625	,		
	2. Resident #59 was 2/24/16 with diagnose heart failure and hype The comprehensive n	es that included, in part, ertension.					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/13/2020 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345129	B. WING		_		C 13/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
DAVIE NU	RSING AND REHABILITA	ATION CENTER		498 MADISON ROAD MOCKSVILLE, NC 2702	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page had cognitive impairm The medical record in representative was a A nurse's note in the re Resident #59 was trai 10/15/19 due to short lung sounds, and low record demonstrated notice of the bed hold resident and resident was transferred to the On 2/13/20 at 1:56 PM completed with the Bu (BOM). She revealed sent with a resident w hospital. The BOM as resident's representat Resident #59's represent discharge to the hosp the resident represent included a copy of the stated that she would Assistant, who would to the resident represent bed hold policy. The letter signature receip one for Resident #59 was real	e 15 nent. dicated Resident #59's family member. medical record reported nsferred to the hospital on ness of breath, abnormal oxygen levels. The medical no evidence that a written policy was provided to the representative when she hospital. M an interview was usiness Office Manager the bed hold policy was then transferred to the dded she typically called a ive and remembered calling sentative to notify her of the ital. The facility also sent tative a certified letter that a bed hold policy. She notify the Administrative then send a certified letter entative that contained the BOM reviewed the certified ts and stated there was not s representative. ddmitted to the facility from treatment for aspiration	F 62				
		I a phone call was placed to sentative but no interview					

Facility ID: 922953

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/13/202 FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/13/2020	
		345129	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
DAVIE NURSING AND REHABILITATION CENTER		ATION CENTER		498 MADISON ROAD MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 625	2/12/20 at 3:01 PM. resident transferred to bed hold policy was as the packet of informa resident to the hospit On 2/13/20 at 10:33 / Administrator revealed was to be sent with th the hospital and a co representative in the	ng was interviewed on She explained that when a pothe hospital a copy of the supposed to be included in tion that was sent with the al. AM an interview with the dot that the bed hold policy he resident upon transfer to py provided to the resident mail. He acknowledged the sistently being followed and	F 62	5		
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status.	of Assessments. It accurately reflect the	F 64	1	3/4/20	
	by: Based on staff interv facility failed to accur diagnoses section (se Data Set (MDS) asse (Resident #7 and Res unnecessary medicat Findings included: 1. Resident #7 was a 8/23/16. Cumulative anxiety disorder and	ection I) on the Minimum ssment for 2 of 5 residents sident #19) reviewed for tions. dmitted to the facility on diagnoses included, in part, depression. ed 10/21/19 stated Resident		Residents #7 and #19 have had the MDS assessment modified and corre Neither resident had any negative outcome from this event. To identify other resident who have t potential to be affected, resident assessments beginning 2/9/2020 ha been reviewed for accuracy by the M coordinators (no coordinator comple their own review). Any noted discrepancies have been corrected to on the guidance from the resident assessment instrument. To prevent this from recurring, the corporate regional resident	ected. he ve IDS ted	

Event ID: K16811

Facility ID: 922953

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP		UCTION		NO. 0938-039 TE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			· · ·	MPLETED
			5.14/010				С
		345129	B. WING			0	2/13/2020
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 498 MADISON ROAD				
DAVIE NU	DAVIE NURSING AND REHABILITATION CENTER			498 MADISON ROAD MOCKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 641	Continued From page	e 17	F 64	1			
	depressive disorder.	5 11	1 04		ursement specialist re-educated	the	
					y MDS nurse coordinators on th		
		8/19, the facility nurse			rement of accurate coding of		
	practitioner indicated medical history of de	Resident #7 had a past			ssments 2/21/2020 rs will be reviewed during clinica	J	
					ng and changes to the MDS wil		
	· ·	ssessment dated 11/17/19		made	as needed based on the review		
		received an anti-depressant			onitor and maintain ongoing		
		days during the lookback no diagnoses were checked			liance, three assessments will b ed weekly for four weeks then tv		
		/mood disorder portion of			ssments will be audited for four	10	
	section I.	·			s, and then one chart will be au	dited	
	On 2/12/20 at 11:20	AM on interview was			ur weeks beginning 2/17/2020.		
	On 2/12/20 at 11:29 / completed with MDS	Nurse #1. She said when			lent assessments are audited by nurses and any additional diagr		
		s on the MDS assessment			dded to resident charts. The		
		an (MD) notes and if the MD			ssments are audited by nurses t	hat	
		ive psychiatric diagnosis			ot perform the initial MDS. esults of the audits will be forwa	rdod	
		ys then she coded it on the he added that if a resident			facility QAPI committee for furt		
		depression or anxiety of if a			w and recommendations for the		
		psychiatric services in the			ion of the auditing.		
		the diagnosis active and		DON	is responsible for compliance.		
		assessment. She explained depression diagnoses					
		ded on the MDS based upon					
	the psychiatry note a	nd thought she must have					
	missed coding it whe quarterly MDS asses						
	-	vith the Administrator on					
		he revealed when a MDS					
		npleted it went through a " among the business office,					
		py office and they made					
		appropriately checked. The					
	Administrator said he	-					
	uagnoses cooing wa	s missed on the MDS					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/13/2020 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		345129	B. WING				C 13/2020
NAME OF P	ROVIDER OR SUPPLIER	0.0.20			STREET ADDRESS, CITY, STATE, ZIP CODE	02/	13/2020
					198 MADISON ROAD		
DAVIE NU	RSING AND REHABILITA	ATION CENTER			MOCKSVILLE, NC 27028		
(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 641	Continued From page	2 18	F	641			
	3/11/19. Cumulative	admitted to the facility on diagnoses included, in part, ression and post-traumatic)).					
	A psychiatry note date #19 had a diagnosis o	ed 12/2/19 stated Resident of PTSD.					
	In a note dated 12/11, practitioner included F for Resident #19.	/19, the facility nurse PTSD in the list of diagnoses					
	12/12/19 revealed Re anti-depressant and a for 7 of 7 days during diagnoses of anxiety checked under the ps	nti-psychotic medications the lookback period. The					
	she coded diagnoses she reviewed physicia medical diagnoses lis typically included all p she coded section I b fluctuate." She indica multiple psychiatric di	Nurse #2. She said when on the MDS assessment an (MD) notes and the					
	2/13/20 at 10:33 AM, assessment was com "triple check process"	ith the Administrator on he revealed when a MDS pleted it went through a among the business office, by office and they made					

Facility ID: 922953

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345129	B. WING			
		345129			02/13/2020	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI		ODE	
DAVIE NURSING AND REHABILITATION CENTER		ATION CENTER		498 MADISON ROAD MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE COMPLET HE APPROPRIATE DATE	
F 641	Continued From page	e 19	F 64	11		
	sure everything was Administrator said he	appropriately checked. The		τ. I		
F 644 SS=D	Coordination of PASA CFR(s): 483.20(e)(1)	ARR and Assessments (2)	F 64	14	3/4/20	
	pre-admission screer (PASARR) program u of this part to the max	tion. nate assessments with the ning and resident review under Medicaid in subpart C kimum extent practicable to ing and effort. Coordination				
	from the PASARR lev PASARR evaluation	rating the recommendations vel II determination and the report into a resident's anning, and transitions of				
	all residents with new serious mental disord related condition for I a significant change i	ng all level II residents and /ly evident or possible ler, intellectual disability, or a evel II resident review upon n status assessment. is not met as evidenced				
	Based on resident at record review, the fac who was hospitalized which resulted in an a diagnosis, for a level and Resident Review	II Preadmission Screening		Resident #19 had a new P/ by social worker, there was the PASRR. To identify oth who have the potential to be residents in facility as of 2/1 audited for current/significal PASRR by the facility social identified residents needing were acted upon and an up	no change in er residents e affected, all I3/2020 were nt change I worker. Any g an update	

Event ID: K16811

Facility ID: 922953

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	-	ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 03/13/2020 FORM APPROVED //B NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3	3) DATE SURVEY COMPLETED
		345129	B. WING				C 02/13/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	RSING AND REHABILIT	ATION CENTER		49	98 MADISON ROAD		
27412110				М	IOCKSVILLE, NC 27028		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 644	Resident #19 was adi 3/11/19 with diagnose anxiety disorder and i She had a level I PAS admission. Resident hospital on 5/8/19 due psychiatric condition. facility on 5/16/19 with ideations. The medic PASARR referral (the screening is to assure serious mental illness Medicaid certified nur appropriate placemer completed by the faci re-admission. The facility completed 5/20/19 which explain "admitted to the hosp discharged back to fa suicidal ideations and The comprehensive M assessment dated 12 #19 was cognitively in symptoms that includ things and feeling tire #19 received antipsyc medications for 7 of 7 back period. A care plan for delusi 1/14/20 and an interv psychiatrist and/or ps On 2/11/20 at 9:55 AM	mitted to the facility on es that included, in part, major depressive disorder. SARR number upon initial #19 discharged to the e to a decline in her She was re-admitted to the h a new diagnosis of suicidal cal record revealed a level II e purpose of the Level II e that individuals with a entering or residing in rsing facilities receive ht and services) was not lity upon the resident's d a psychiatric evaluation on hed Resident #19 was ital 5/8/19 and was ital 5/8/19 and was itility on 5/16/19 due to d paranoia." Minimum Data Set (MDS) 2/12/19 indicated Resident intact. She reported mood ed having little interest in ed/little energy. Resident chotic and antidepressant d' days during the MDS look	F	644	Residents did not have any negati outcome from this event. To prevent this from recurring, the Social Worker and Admissions Department were educated by the Corporate Director of Social Servi Activities on the process for apply PASRRs on 2/27/2020. During clinical review, the IDT will any new changes or needs that m require a PASRR referral or updat social worker will apply for a new for all residents returning from a hospitalization with a significant ch status. To monitor and maintain ongoing compliance, the facility administra audit three residents per week for weeks that return from hospitaliza determine if a Level II PASRR was for if needed beginning on 2/28/20 The facility social worker will revie resident charts per week for 12 we ensure that there has not been a significant change that would requ PASRR referral. These results wi documented on an audit tool. The results of the audits will be for to the facility QAPI committee for the review and recommendations for the duration of the auditing. Administrator is responsible for compliance.	e facility ces and ing for identify ay te. The PASRR hange ir tor will 12 tion to s applied 20. w 3 eeks to J20. w 3 eeks to lire a Il be rwarded further	d

Facility ID: 922953

If continuation sheet Page 21 of 31

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 03/13/202 RM APPROVE NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345129	B. WING				C)2/13/2020
NAME OF PR	ROVIDER OR SUPPLIER	•		STR	REET ADDRESS, CITY, STATE, ZIP CODE	· ·	
DAVIE NURSING AND REHABILITATION CENTER			498	MADISON ROAD			
DAVIE NO	KJING AND KEHABILIT	ATION CENTER		МО	OCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 644	Continued From page	ə 21	F 6	44			
	PASARR number.						
		W. She reported the ified PASARR numbers					
	stated she was unaw	dmission to the facility. She are that a level II PASARR ted when a resident was					
	identified with a ment	al illness diagnosis.					
		rdinator (AC) was 0 at 9:35 AM. She stated social worker in May 2019					
	when Resident #19 w	vas transferred to the					
		e resident had received n the facility for about two					
	weeks yet on 5/8/19 suicidal ideation with	was delusional and endorsed a plan. The facility					
	department and the r	sident #19 to the emergency esident was admitted to the					
	the resident returned	c care. The AC stated when to the facility she had not PASARR referral and added					
	she had not done lev						
	diagnosis. She said, should have done on	"Honestly, I didn't know I e."					
	at 9:31 AM, she reca	/ith Resident #19 on 2/13/20 lled in May 2019 she had					
	hospital. While in the stated her psychiatric	nerself and was sent to the hospital Resident #19 medications were adjusted					
	her return to the facili	the acknowledged that since ty she had seen a therapist rapy and had felt well.					
	On 2/12/20 at 2:15 P completed with the A	M an interview was dministrator. He reported					

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/13/202 FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345129	B. WING		C 02/13/2020	
NAME OF PI	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP COI	DE	
DAVIE NURSING AND REHABILITATION CENTER			MADISON ROAD CKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETIO E APPROPRIATE DATE	
F 644	PASARR referrals. H the facility and recent	e 22 ible for completing level 2 le said the SW was new to tly had received education fice regarding the level 2	F 644			
F 732 SS=C	must post the followin basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categ unlicensed nursing st resident care per shif (A) Registered nurse (B) Licensed practica vocational nurses (as (C) Certified nurse ai (iv) Resident census. §483.35(g)(2) Posting (i) The facility must p specified in paragrap daily basis at the beg (ii) Data must be pos (A) Clear and readab (B) In a prominent pla residents and visitors §483.35(g)(3) Public staffing data. The fac written request, make	-(4) affing Information. equirements. The facility ng information on a daily and the actual hours worked gories of licensed and taff directly responsible for ft: s. al nurses or licensed a defined under State law). des. g requirements. ost the nurse staffing data h (g)(1) of this section on a ginning of each shift. ted as follows: le format. acce readily accessible to s. access to posted nurse cility must, upon oral or	F 732		3/4/20	

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/13/20 FORM APPROVE OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED	
		345129	B. WING		C 02/13/2020	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
DAVIE NURSING AND REHABILITATION CENTER			498 MADISON ROAD MOCKSVILLE, NC 27028			
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION	
F 732	Continued From page	23	F 73	2		
	posted daily nurse sta 18 months, or as requising greater. This REQUIREMENT by: Based on observationinterviews, the facility staffing data was posed 23 of the 46 dates rewised failed to complete and nurse staffing data for reviewed. Findings included: 1. During the initial to 9:30 a.m., the daily midate of 2/7/20 was ob- lobby. Review of the facility's through 2/13/20 indic staffing postings were 1/3/20, 1/4/20, 1/5/200 1/12/20, 1/13/20, 1/15 1/18/19, 1/19/20, 1/20 1/24/20, 1/25/20, 1/20 2/8/20. During an interview of staffing Scheduler co- nursing staff postings and or not maintained facility was required to	acility must maintain the affing data for a minimum of uired by State law, whichever is not met as evidenced ns, record reviews, and staff failed to ensure nurse ted daily and maintained for viewed. The facility also d accurately record the		The facility staff posting was con and reflected accurate census a staffing by the end of the survey residents suffered any negative as a result of this event. To identify other residents who h potential to be affected, the staff scheduler, payroll coordinator, a facility administrator completed a from 2-1-2020 to date of exit of s posting, and corrections made a identified. To prevent this from recurring, th scheduler was educated by adm on accuracy of staff posting requ on 2/17/2020. Clinical manage received completed education of 3/2/2020, on updating and verify posting by the director of nursing new hired clinical managers will this same education. The daily s posting will be updated to reflect census and staff by the facility se or designee. To monitor and maintain ongoing compliance, staffing sheets will k reviewed in morning meeting for weeks, beginning 3/2/2020 by th administrator. Any inaccuracies corrected. These results will be documented on an audit tool.	nd exit. No outcomes have the ind the audits staff s he facility inistrator uirements ers n ing staff g. Any receive staff accurate cheduler	

Facility ID: 922953

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		O. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
					С	
		345129	B. WING			2/13/2020
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
DAVIE NURSING AND REHABILITATION CENTER				498 MADISON ROAD MOCKSVILLE, NC 27028		
(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)	I SHOULD BE	(X5) COMPLETIO DATE
F 732	Continued From page	24	Г 72			
F 732	Continued From page 24 revealed she was the facility's only nursing staff scheduler and she completed and posted the daily nurse staffing. She stated most of the missing dated nursing staff postings coincided with the dates she worked at the facility as a nursing assistant or on the dates in which she did not work. During an interview on 2/13/20 at 2:27 p.m., the Administrator stated his expectation was that the facility complied with the regulations with daily posting of nurse staffing data. 2. Review of the facility's daily nurse staffing postings dated 12/30/19 through 2/13/20 revealed incomplete and inaccurate nurse staffing data on 12/30/19, 12/31/19, 1/2/20, 1/6/20, 1/7/20, 1/8/20,		F 73	The results of the audits will b to the facility QAPI committee review and recommendations duration of the auditing. DON is responsible for compl	for further for the	
	1/30/20, 1/31/20, 2/3/ 2/7/20, and 2/12/20. during second and th number of staff by ca hours worked for eac census number recor greater than the num facility indicating the assistant living reside posted on the daily n nursing staff were inc the hours the staff wor resided in the facility'	7/20, 1/28/20, 1/29/20, /20, 2/4/20, 2/5/20, 2/6/20, There was no data recorded ird shifts for census, total tegory, and total number of h staffing category. Also, the ded on the postings were ber of certified beds in the census number included the ents. Additionally, the hours ursing staffing sheet for the correct because it included orked with the residents who s Assisted Living (AL) rooms				
	assignment sheets. During an observatio	ew of the daily nursing n on 2/10/20 at 9:24 a.m., ig data posted in the lobby of				

If continuation sheet Page 25 of 31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) DENTIFICATION NUMBER: (X2) MAILTPLE CONSTRUCTION A BUILDING (X2) MAILTPLE CONSTRUCTION A BUILDING (X3) DATE SUP- COMPLET NAME OF PROVIDER OR SUPPLIER 345129 STREET ADDRESS, CITY, STATE, 21P CODE 498 MADISON ROAD MOCKSYLLE, NC 27028 DAVE NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, 21P CODE 498 MADISON ROAD MOCKSYLLE, NC 27028 STREET ADDRESS, CITY, STATE, 21P CODE 498 MADISON ROAD MOCKSYLLE, NC 27028 F7 732 Continued From page 25 During an interview on 2/11/20 at 2:30 p.m., the Administrator stated there were a total of 108 beds in the facility of which only 96 beds were cardified. He stated thar only 92 of the 96 cardified beds were currently occupied. He revealed the census number on the daily nurse staffing posted in the facility include both cartified and non-cardified beds. F 732 During an interview on 2/11/20 at 2:30 p.m., the Administrator stated there were a total of 108 beds in the facility of which only 96 beds were cardified. He stated that only 203 p.m., the Staffing Scheduler confirmed she was responsible for entering the data on the facility's daily nurse staffing form and posting the form in the loby of the facility. The Staffing Scheduler revealed she only worked at the facility during first shift, Monday through Friday and only during the sestimation. The include the was unaware that she was to separate the census at third shift would have completed the data on the posted nurse staffing. The stated the analy nurse staffing form. She stated the cality during first shaffing torm. She stated the facility during first staffing form. She stated the facility during first staffing form. She stated the facility during fin			ND HUMAN SERVICES MEDICAID SERVICES			FC	TED: 03/13/2020 DRM APPROVED NO. 0938-039	
345129 Divide 00/13/2 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE DAVE NURSING AND REHABILIZATION CENTER DAVE NURSING AND REHABILIZATION CENTER STREET ADDRESS, CITY, STATE, 2P CODE (%1)D STREET ADDRESS, CITY, STATE, 2P CODE (%4)D STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE OUTONE STREAM OF OPERCIPACES UP CODE STREET ADDRESS, CITY, STATE, 2P CODE CONTRACTORY ON LEC IDENTIFYING INFORMATION) DEFICIENCY IDENTIFYING ADDRESS FUNCTION TO STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE DEFICIENCY Continued From page 25 DUTING INTERVIEW OF OPERCIPACIES DUTING STATE, 2P CODE </th <th colspan="2"></th> <th>(X1) PROVIDER/SUPPLIER/CLIA</th> <th>` ´</th> <th></th> <th>(X3) D</th> <th colspan="2">(X3) DATE SURVEY COMPLETED</th>			(X1) PROVIDER/SUPPLIER/CLIA	` ´		(X3) D	(X3) DATE SURVEY COMPLETED	
Invale of PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, 21P CODE DAVIE NURSING AND REHABILITATION CENTER Interview CAN DISTRET PROVIDER STATE, 21P CODE IMAGE ISSUMMARY STATEMENT OF DEFICIENCIES Interview CAN DISTRET PROVIDER STATE, 21P CODE IPACID ISSUMMARY STATEMENT OF DEFICIENCIES Interview CAN DISTRET PROVIDER STATE, 21P CODE IPACID ISSUMMARY STATEMENT OF DEFICIENCIES Interview CAN DISTRET PROVIDER STATE, 21P CODE IPACID IPACULATIONY OR LSC DENTIFYING INFORMATION) IPAC F 732 Continued From page 25 IPACID During an interview on 2/11/20 at 2:30 p.m., the F 732 During an interview on 2/13/20 at 2:03 p.m., the F 732 During an interview on 2/13/20 at 2:03 p.m., the Staffing Scheduler revealed she only worked at the facility during first shift, Monday through Friday and only during the verealed the census staffing form and posting the form in the lobby of the facility, The Staffing Scheduler revealed she only worked at the facility during the second and third shifts would have completed the data on the posted nurse staffing scheduler revealed she only worked at 2:32 p.m., the Administrator stated the facility during the second and third shifts would have completed the data on the posted nurse staffing scheduler revealed she only worked at the facility during the second and third shifts would have completed the data on the posted nurse staffing scheduler in complete and post the dataly nuruse staffing formation when she did not work in this role.			345129	B. WING			02/13/2020	
DAVE NURSING AND REHABILITATION CENTER MOCKSVILLE, NC 27028 (X4)[0] PREFIX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST & FRECEDED BY ULL REGULATORY OR LSCIDENTIFYING INFORMATION) D IN TAG D PROVIDENTIFY AND RECOMMENTIFY AND RECENT ANTON (EACH DEFICIENCY MUST & FRECEDED BY ULL REGULATORY OR LSCIDENTIFYING INFORMATION) D IN TAG F 732 Continued From page 25 During an interview on 2/11/20 at 2:30 p.m., the Administrator stated there were a total of 108 beds in the facility of which only 89 of the 96 certified beds were currently occupied. He revealed the census number on the daily nurse statifing posted in the facility's lobby included both certified and non-certified beds. F 732 During an interview on 2/13/20 at 2:03 p.m., the Statifing Scheduler confirmed she was responsible for entering the data on the facility's daily nurse statifing form and posting the form in the lobby of the facility during the weekend as a nursing assistant if a scheduled nursing assistant was unable to work. She stated she assumed a nurse on duly during the weekend as a nursing assistant if a scheduled nursing assistant the schilded beds and Assisted Living (AL) residents on the daily nurse statifing form. She stated the acrus data of the residents in the skilled beds and Assisted Living (AL) residents on the daily nurse statifing form. She stated the acrus statifing form. She stated the acrus data of the residents in the skilled beds and Assisted Living (AL) residents on the daily nurse statifing form. She stated the acrus statifing form. Inset stated the facility during the posting of nurse statifing information when she did not work in this role. F 760 Si4 Si4 During an interview on 2/13/	NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
CALL MOCKSVILLE, NC 27028 PALID PREFIX TAG SUMMARY STATURENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) CC F 732 Continued From page 25 During an interview on 2/11/20 at 2:30 p.m., the Administrator stated there were a total of 108 beds in the facility of which only 950 beds were certified. He stated that only 89 of the 95 contified beds were currently occupied. He revealed the census number on the daily nurse staffing posted in the facility's lobby included both certified and non-correctified beds. F 732 During an interview on 2/13/20 at 2:03 p.m., the Staffing Scheduler confirmed she was responsible for entering the data on the facility's daily nurse staffing form and posting the form in the lobby of the facility. The Staffing Scheduler revealed she only worked at the facility during first shift, Monday through Friday and only during the weekend as a nurse on duly during the second and third shifts would have completed the data on the posted nurse staffing. She indicated she was unaware that she was to separate the census data of the residents in the skilled beds and Assisted Living (AL) residents on the daily nurse statifing form. She stated the facility did not have a back-up staffing scheduler to complete and post the daily nurse staffing formation when she did not work in this role. F 760 SS-D Si4 Si4 Si4 F 7760 SS-D CFR(s): 483.45(0/2) The facility must ensure that its- Si4 Si4		RSING AND REHABILIT	ATION CENTER		498 MADISON ROAD			
Price (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDMIFYING INFORMATION) PRETX TAG C(EACH DEFICIENCY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C F 732 Continued From page 25 During an interview on 2/11/20 at 2:30 p.m., the Administrator stated there were a total of 108 beds in the facility of which only 96 beds were certified. He stated that only 89 of the 96 certified beds were currently occupied. He revealed the census number on the daily nurse staffing posted in the facility's lobby included both certified and non-certified beds. F 732 During an interview on 2/13/20 at 2:03 p.m., the Staffing Scheduler confirmed she was responsible for metering the data on the facility's daily nurse staffing form and posting the form in the lobby of the facility. The Staffing Scheduler nervealed she only worked at the facility during first shift. Monday through Friday and only during the weekend as a nurse on duly during the second and third shifts would have completed the data on the posted nurse staffing formation when she did not work in this exliled beds and Assisted Living (AL) residents on the daily nurse staffing form. She stated the facility did not have a back-up staffing scheduler to complete and post the daily nurse staffing formation when she did not work in this role. F 760 3/4 F 770 SS-D CFR(s): 483.45(f)(2) The facility must ensure that its- 5 5 5 5 5	2/11/2 110				MOCKSVILLE, NC 27028			
During an interview on 2/11/20 at 2:30 p.m., the Administrator stated there were a total of 108 beds in the facility of which only 96 beds were certified. He stated that only 99 of the 96 certified beds were currently occupied. He revealed the census number on the daily nurse staffing posted in the facility's lobby included both certified and non-certified beds. During an interview on 2/13/20 at 2:03 p.m., the Staffing Scheduler confirmed she was responsible for entering the data on the facility's daily nurse staffing form and posting the form in the lobby of the facility. The Staffing Scheduler revealed she only worked at the facility during first shift, Monday through Friday and only during the weekend as a nursing assistant if a scheduled nursing assistant was unable to work. She stated she assumed a nurse outly during the second and third shifts would have completed the data on the posted nurse staffing. She indicated she was unawned at the skilled beds and Assisted Living (AL) residents on the daily nurse staffing form. She stated the facility did not have a back-up staffing scheduler to complete and post the daily nurse staffing information when she	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	F 760	During an interview of Administrator stated beds in the facility of certified. He stated th beds were currently of census number on th in the facility's lobby non-certified beds. During an interview of Staffing Scheduler cor responsible for enter daily nurse staffing for the lobby of the facilit revealed she only wo shift, Monday through weekend as a nursin nursing assistant was she assumed a nurse and third shifts would the posted nurse staff unaware that she wa data of the residents Assisted Living (AL) is staffing form. She staff a back-up staffing sc post the daily nurse staff did not work in this ro During an interview of Administrator stated facility complied with posting of nurse staff Residents are Free of	on 2/11/20 at 2:30 p.m., the there were a total of 108 which only 96 beds were hat only 89 of the 96 certified occupied. He revealed the he daily nurse staffing posted included both certified and on 2/13/20 at 2:03 p.m., the onfirmed she was ing the data on the facility's orm and posting the form in ty. The Staffing Scheduler orked at the facility during first h Friday and only during the g assistant if a scheduled s unable to work. She stated e on duty during the second d have completed the data on ffing. She indicated she was s to separate the census in the skilled beds and residents on the daily nurse ated the facility did not have heduler to complete and staffing information when she ole.		32	CY)	3/4/20	

Facility ID: 922953

If continuation sheet Page 26 of 31

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 03/13/202 APPROVE . 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
	345129		B. WING		02/1	; 3/2020
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ē		
	RSING AND REHABILIT			498 MADISON ROAD		
DAVIE NU	KSING AND KEHABILIT	Anon Center		MOCKSVILLE, NC 27028		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	Continued From page	e 26	F 760			
	medication errors.					
		Γ is not met as evidenced				
	by:					
	Based on record rev			Resident #85 no longer reside	es in the	
		sician interviews the facility gnificant medication error by		facility. To identify other residents who	have the	
		esident's anticoagulant		potential to be affected, medic		
		on two consecutive days and		records for current residents v		
	failed to notify the on	-call nurse practitioner or		receiving anticoagulant medic	ations were	
		ed doses because of the		audited for the last 7 days sind		
	resident's altered me			exit on 2/13/2020. No discrep	ancies	
	residents' (Resident #	#85) closed charts reviewed.		found.		
	Findings included:			To prevent this from recurring director of nursing or clinical n completed education on 2/28/	nanager	
	Resident #85 was ad	mitted to the facility on		nurses and medication aides		
		ospitalization for left radius		administering anticoagulant m	edications	
	• •	uction internal fixation		per MD order and contacting a		
	(ORIF) after sustainir	ng a fall at home.		anticoagulants are unable to b	-	
	Poviow of Posidont #	ter's Admission Minimum		ordered. This education will b	-	
		#85's Admission Minimum //19, progress notes, and		to any new hired nurses and r aides and any agency nurses		
		ed that Resident #85 had		medication aides.		
		vas alert and able to make		Medication administration of		
	needs known and rec	quired a one-two-person		anticoagulation medications w		
		with activities of daily living.		reviewed for administration at		
	•	ed, in part, atrial fibrillation,		morning meeting. Any identifie	ed concerns	
		t distal radial and left nal end of femur) fractures.		will be followed up on. To monitor and maintain ongo	ina	
		nar end or remur / fractures.		compliance, beginning 2/23/20	•	
	Review of progress n	otes, diagnostic results, and		DON will audit 5 residents who		
		vealed that Resident #85		anticoagulant medications we		
	had noted left lower left	eg swelling, the on-call nurse		weeks, to ensure administration	on of the	
	•	ied, and a physician's order		medication was completed as		
		20 for a venous ultrasound of		Any negative findings will be a		
		ty. The ultrasound was		immediately. The results of th	e audit will	
	-	D, the results of "evidence of t lower extremity deep		be documented. The results of the audits will b	e forwardod	
1						

Facility ID: 922953

						10.0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
						С
		345129	B. WING		0	2/13/2020
NAME OF P	ROVIDER OR SUPPLIER	·	•	STREET ADDRESS, CITY, STATE, ZIP CODE		
DAVIE NURSING AND REHABILITATION CENTER				498 MADISON ROAD MOCKSVILLE, NC 27028		
(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) COMPLETIOI DATE
F 760	Continued From page	e 27	F 76	:0		
	on-call provider, and orders were placed for Xarelto Tablet 15 milligrams (MG) (Rivaroxaban) 15 mg by mouth every 12 hours for Left Lower Extremity DVT for 21 Days on 1/16/20.			review and recommendations f duration of the auditing. DON is responsible for complia		
	revealed that the resi take her ordered med	85's Medication d and progress notes dent was not alert enough to dications on 1/18/20 and eceive her Xarelto on either				
	05:02 PM she stated alert enough to take I and 1/19/20 at 8:00 F her ordered medication	vith Nurse #2 on 2/11/20 at that Resident #85 was not her medications on 1/18/20 PM, she did not administer ons, including Xarelto, and sician or on-call nurse ssed doses.				
	2/11/20 at 04:02 PM = Resident #85 daily du through 1/17/20 due labs reported, and the that was found on 1/1 asked if she would ex provider of missed do status changes, she change in condition w	oses of Xarelto and mental stated that if there was a where Resident #85 was not				
	missed doses of orde on-call provider shou change. When asked missed doses of Xare DVT, she stated that	her medications and/or ered medications that the Id have been notified of the d about Resident #85's elto ordered to treat her it would increase the risk of for the resident if not taken				

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/13/20 FORM APPROVE 0MB NO: 0938-03
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129				CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		B. WING		02/13/2020	
NAME OF PF	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE	
	RSING AND REHABILIT	ATION CENTER			
				IOCKSVILLE, NC 27028	
(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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F 760	Continued From page	e 28	F 760		
		vith the Director of Nursing			
	on 2/12/20 at 11:05 A	M when asked about			
		ed doses of medications on			
		at 8:00 PM, she stated that f the situation shortly after			
	and had started/imple	-			
	-	dress it. She stated that it			
	•	that a nurse practitioner or			
		of missed medication doses, sk medications like Xarelto.			
		to all staff to notify and			
		atus changes and failure to			
	receive ordered med	ications for any reason.			
	During an interview v	vith Physician #1 on 2/12/20			
		ked if the nursing staff			
		ed the on-call provider 85's cognitive status change			
		Xarelto, she stated yes.			
		gative outcomes could have			
		dent #85 not receiving her			
	Xarelto as ordered, s	he stated "possible" dent's current blood clot and			
	other blood clots wer				
F 814	Dispose Garbage an		F 814		3/4/20
SS=C	CFR(s): 483.60(i)(4)				
	§483.60(i)(4)- Dispos	e of garbage and refuse			
	properly.	, ,			
		Γ is not met as evidenced			
	by: Based on observation	ons and staff interviews, the		Trash was cleaned up around dumpste	rs
		e the side doors and top lids		and doors were closed prior to 2/13/202	
		emained closed when not in		The area is clean and free of debris. No	
		rounding the dumpsters		resident suffered any negative outcome	
	remained free from g	arbage and reluse.		as a result of this event. All residents have the potential to be	
	Findings included:			affected. Dietary manager and	

Event ID: K16811

Facility ID: 922953

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129			· ,	PLE CONSTRUCTION	(X3) D.	NO. 0938-03
		B. WING _			C 02/13/2020	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STAT		
				498 MADISON ROAD		
DAVIE NU	RSING AND REHABILIT	ATION CENTER		MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIC DATE
F 814	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 During the initial tour of the facility on 2/9/20 at 10:49 a.m., two dumpsters were observed enclosed within a wooden fence. The side door of 1 of 2 of the dumpsters was open. The top lids of both dumpsters were open with bags of trash hanging out of the tops onto the sides of the dumpsters. There were multiple soiled gloves, plastic cup lids, paper, used cigarettes, and plastic spoons on the ground surrounding the dumpsters. During an observation on 2/12/20 at 2:40 p.m., the side doors of 2 of 2 dumpsters were open (bags of trash in each dumpster). There were 2-soiled gloves and 2-used cigarettes on ground surrounding the dumpsters. During an interview on 2/12/20 at 2:43 p.m., the Dietary Manager revealed the facility's housekeeping and maintenance services were responsible for ensuring the dumpster area was clean and free from debris. She stated the dietary staff were instructed to keep the doors to dumpsters closed after discarding bags of trash.		F8	maintenance director area through the rem any area of concern To prevent this from and housekeeping st completed educated maintaining the dump keeping dumpster do by the administrator Random review of th be conducted as an of the facility housekee dietary manager. To monitor and main compliance,Dietary M Maintenance Directo dumpsters and dump for 12 weeks, beginn 2/24/2020. The resul documented.	recurring, the dietary taff received on properly pster area and oors and lids closed on 2/28/2020. e dumpster area will ongoing process by ping supervisor and tain ongoing Manager or or will audit the oster area 5x weekly, ning the week of ts of the audit will be dits will be forwarded ommittee for further endations for the ng.	
	Environmental Servic environmental servic transferred trash from dumpsters twice duri all facility staff used t	n the facility to the ng each shift. He indicated he dumpsters and the vere instructed to ensure the ers were closed after				
		on 2/12/20 at 3:00 p.m., the he expected, and staff				

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		ID HUMAN SERVICES				FORM	APPROVED	
		MEDICAID SERVICES					0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
			A. BUILDI					
	345129					02/13/2020		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	RSING AND REHABILIT			49	98 MADISON ROAD			
DAVIE NU		ATION CENTER		N	IOCKSVILLE, NC 27028			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
					DEFICIENCY)			
F 814	Continued From page		F	814				
		are to keep the doors to the						
	them.	er bags of trash were put in						

Event ID: K16811

Facility ID: 922953

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