PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245222					С	
		345323	B. WING _			04/	14/2021	
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	NTRR HEALTH & REHA	BILITATION WALLACE			7 S RAILROAD STREET BOX 966			
				W	ALLACE, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
E 000	Initial Comments		E	000				
F 000		3.73, Emergency t ID #6ZNL11.	F	000				
		complaint investigation d from 04/05/21 through ZNL11.						
F 550 SS=D	1 of the 53 complain substantiated. Resident Rights/Exer CFR(s): 483.10(a)(1)	cise of Rights	F 5	550			4/29/21	
	self-determination, ar	ght to a dignified existence, nd communication with and						
	with respect and dign resident in a manner promotes maintenand	and in an environment that be or enhancement of his or ognizing each resident's lity must protect and						
	access to quality care severity of condition, must establish and m practices regarding tr provision of services	cility must provide equal eregardless of diagnosis, or payment source. A facility aintain identical policies and cansfer, discharge, and the under the State plan for all						
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	

Electronically Signed 05/07/2021

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345323	B. WING _			C <b>4/14/2021</b>	
	ROVIDER OR SUPPLIER	ABILITATION WALLACE		STREET ADDRESS, CITY, STATE, ZIP CODI 647 S RAILROAD STREET BOX 966 WALLACE, NC 28466		71-72-02-1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 550	residents regardless §483.10(b) Exercise The resident has the rights as a resident or resident of the Uri §483.10(b)(1) The firesident can exercise interference, coerciform the facility.  §483.10(b)(2) The rifree of interference, reprisal from the facility.  §483.10(b)(2) The rifree of interference, reprisal from the facility and to be sup exercise of his or he subpart. This REQUIREMEN by:  Based on observative resident interviews to dignity by failing to be permission to enter #32, Resident #26 at Findings included:  1. Resident #32 was 09/16/2019. The moduli of the part of	e of Rights. e right to exercise his or her of the facility and as a citizen nited States.  acility must ensure that the se his or her rights without on, discrimination, or reprisal esident has the right to be coercion, discrimination, and sility in exercising his or her ported by the facility in the er rights as required under this as required under this er rights as required under this and the facility failed to maintain knock on doors or ask for 3 of 6 residents (Resident and Resident #33).  It is admitted to the facility on the entire that the facility of the street quarterly Minimum and the facility cognitively impaired press his ideas and wants.  It is not met as evidenced the facility on the street quarterly Minimum and the facility on the street quarterly Minimum and the facility cognitively impaired press his ideas and wants.  It is not met as evidenced the facility on the street quarterly Minimum and the facility on the facility on the street quarterly Minimum and the facility on the facility on the street quarterly Minimum and the facility on	F 5	"Preparation and/or execution of correction does not constituadmission or agreement by the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of corresprepared and/or executed sole it the required by the provision and state law."  What corrective action will be accomplished for those reside have be affected by the deficiencies. Element #1  Per the 2567, on 4/5/2021, Nature of the provision of the provision and state law."	e provider of r atement of ection is ely because as of federal ents found to ent practice:  A #1 was resident		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245222	B. WING			С	
NAME OF D	201/1050 00 01 1001 150	345323	B. WING _	OTDEET ADDRESS SITY STATE ZID OOF		4/14/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	)E		
BRIAN CE	NTRR HEALTH & REHA	ABILITATION WALLACE		647 S RAILROAD STREET BOX 966			
				WALLACE, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 550	Continued From pag	e 2	F 55	50			
F 550	During an interview of 8:36 AM, NA #1 states supposed to knock of wait to be told to corrooms. NA #1 also she did not do it.  During an interview of 04/06/2021 at 8:39 And the would expect state coming into his room.  During an interview of 04/06/2021 at 4:20 Fisher expects the stafe permission to enter a state of the staff permission to enter a compact of the staff on 04/07/2021 at 05 before entering an everyone stated, "Kreentering", so they all them to knock before 2. Resident #26 was 01/28/2020. The mo	with NA #1 on 04/06/2021 at ed she knows she was on the resident's doors and the in before entering their tated she didn't know why with Resident #32 on AM, the Resident stated that ff to knock on the door before in.  with the Administrator on PM, the Administrator stated ff to knock and wait to get all resident's rooms.  Interview with the Director of 4/08/2021 at 10:33 AM, the is a meeting with the 3-11 shift and asked, "What should you residents room" and nock on the door before know that it is expected of the entering a residents room.  In admitted to the facility on st recent annual Minimum and 02/04/2021 had Resident	F 58	#32, resident # 26, and reside did not knock or wait prior to resident room. Upon identific #1 entering resident rooms picknocking and waiting, educat Resident rights including knoresident door prior to entering completed immediately with Madverse outcomes were identificated by the deficient practive will be put in systematic changes made to deficient practice does not retelement #3  Education was provided to all Director of Nursing on 4/8/20 Resident rights to include knoresident room doors and wait prior to entering a resident room the deficient of the entering a resident room doors will not recur, and what quality will not recur, and what quality and resident room and wait quality and resident room, and what quality will not recur, and what quality and resident room.	entering the cation of NA rior to ion on cking on the g was NA #1. No tified.  al to be tice.  to place or ensure the cur:  I staff by the 21 on ocking on ting to enter om.  ill be sient practice		
	pass on 04/05/2021 walking into Resider without knocking and During an interview 8:36 AM, NA #1 state	on of the 300 Hall breakfast at 8:23 AM, NA #1 was seen at #26's room with a food tray d waiting to be invited in.  with NA #1 on 04/06/2021 at ed she knows she was on the resident's doors and		To ensure ongoing compliant Director of Nursing and/or de conduct compliance audits w weeks to ensure staff are known resident doors and waiting to entering a resident room. The	ce, the signee will eekly x 12 ocking on enter prior to		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345323	B. WING _				C <b>14/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	14/2021
					47 S RAILROAD STREET BOX 966		
BRIAN CE	NTRR HEALTH & REHA	BILITATION WALLACE			VALLACE, NC 28466		
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F 550	Continued From page	e 3	F 5	550			
		e in before entering their ated she didn't know why			provide education on any areas of concern.		
	During an interview w 04/06/2021 at 8:39 Al	with Resident #26 on M, the Resident stated that to knock on the door before			The results of the audits will be reporte at the monthly QAPI meeting until such time that substantial compliance has bachieved x 3 months.	1	
	04/06/2021 at 4:20 P	vith the Administrator on M, the Administrator stated to knock and wait to get Il resident's rooms.			Compliance Date: 4/29/2021		
	Nursing (DON) on 04 DON stated she had staff on 04/07/2021 a do before entering a reveryone stated, "kno	ock on the door before ow that it is expected of them					
	08/22/2019. The mos Data Set (MDS) date	admitted to the facility on t recent quarterly Minimum d 02/17/2021 had Resident ly cognitively impaired.					
	pass on 04/05/2021 a walking into Resident without knocking and	n of the 300 Hall breakfast at 8:25 AM, NA#1 was seen #33's room with a food tray waiting to be invited in.					
	8:36 AM, NA #1 state supposed to knock or wait to be told to com						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345323	B. WING				C 14/2021
	ROVIDER OR SUPPLIER	BILITATION WALLACE	1	6	STREET ADDRESS, CITY, STATE, ZIP CODE 147 S RAILROAD STREET BOX 966 VALLACE, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585 SS=D	Continued From page During an interview of 04/06/2021 at 4:20 P she expects the staff permission to enter a During a telephone in Nursing (DON) on 04 DON stated she had staff on 04/07/2021 ado before entering a everyone stated, "kne entering", so they knot oknock before enter Grievances CFR(s): 483.10(j)(1)-\$483.10(j) Grievances \$483.10(j)(1) The resignity of the fact that hears grievances to the fact that hears grievances reprisal and without freprisal. Such grievarespect to care and the furnished as well as furnished, the behavior residents, and other facility stay.  §483.10(j)(2) The residents make processive grievances the accordance with this \$483.10(j)(3) The fact	with the Administrator on M, the Administrator stated to knock and wait to get all resident's rooms.  Interview with the Director of M/0/2021 at 10:33 AM, the a meeting with the 3-11 shift and asked, "What should you residents room" and ock on the door before ow that it is expected of them ring a residents room.  (4)  Is.  Isident has the right to voice illity or other agency or entity is without discrimination or fear of discrimination or fear of discrimination or fear of staff and of other concerns regarding their LTC isident has the right to and the ompt efforts by the facility to the resident may have, in	F	550	DEFICIENCY)		4/29/21
	residents, and other facility stay.  §483.10(j)(2) The resfacility must make processory grievances that accordance with this  §483.10(j)(3) The factor how to file a griev	sident has the right to and the compt efforts by the facility to be resident may have, in paragraph.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345323	B. WING			04/	14/2021
	ROVIDER OR SUPPLIER	BILITATION WALLACE		6	STREET ADDRESS, CITY, STATE, ZIP CODE 647 S RAILROAD STREET BOX 966 VALLACE, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	of all grievances regacentained in this paraprovider must give a contained in this paraprovider must give a contained in this paraprovider must give a contained in the resident. The grinclude:  (i) Notifying resident it postings in prominent facility of the right to formaning spoken) or grievances anonymous of the grievance officican be filed, that is, haddress (mailing and number; a reasonable completing the review to obtain a written degrievance; and the contained pendent entities to be filed, that is, the populatity Improvement Agency and State Looprogram or protection (ii) Identifying a Griev responsible for overstreceiving and tracking conclusions; leading a by the facility; maintainformation associate example, the identity grievances submitted written grievance decordinating with statinecessary in light of so (iii) As necessary, take	ility must establish a asure the prompt resolution arding the residents' rights agraph. Upon request, the copy of the grievance policy rievance policy must andividually or through a locations throughout the file grievances orally in writing; the right to file usly; the contact information all with whom a grievance is or her name, business email) and business phone is expected time frame for and of the grievance; the right cision regarding his or her contact information of with whom grievances may be expected time frame for and advocacy system; ance Official who is eeing the grievance process, agrievances through to their any necessary investigations ining the confidentiality of all d with grievances, for of the resident for those anonymously, issuing isions to the resident; and e and federal agencies as specific allegations; ining immediate action to tial violations of any resident	F	585			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345323	B. WING _		04	C 1/14/2021	
	ROVIDER OR SUPPLIER	HABILITATION WALLACE		STREET ADDRESS, CITY, STATE, ZIP CO 647 S RAILROAD STREET BOX 966 WALLACE, NC 28466			
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F 585	reporting all allege abuse, including i and/or misapprop anyone furnishing provider, to the act as required by State (v) Ensuring that a include the date it summary statementhe steps taken to summary of the pregarding the resi as to whether the confirmed, any contaken by the faciliand the date the vector (vi) Taking appropraccordance with sof the residents' rior if an outside enthe State Survey of Organization, or loconfirms a violation rights within its and (vii) Maintaining enesult of all grieva 3 years from the indecision.  This REQUIREMENTS absent of the production of the residents of the residents' rights within its and (vii) Maintaining enesult of all grieva 3 years from the indecision.  This REQUIREMENTS absent of the production of the residents of the residents of the state of the production of the prod	h §483.12(c)(1), immediately ed violations involving neglect, njuries of unknown source, riation of resident property, by services on behalf of the Iministrator of the provider; and ate law; all written grievance decisions ne grievance was received, a ant of the resident's grievance, investigate the grievance, a ertinent findings or conclusions dent's concerns(s), a statement grievance was confirmed or not rrective action taken or to be by as a result of the grievance, written decision was issued; riate corrective action in State law if the alleged violation ghts is confirmed by the facility tity having jurisdiction, such as Agency, Quality Improvement ocal law enforcement agency on for any of these residents' the angles of responsibility; and vidence demonstrating the noces for a period of no less than assuance of the grievance  ENT is not met as evidenced therefore and record review, the covide written responses to Resident #20) of 3 residents ances.	F	"Preparation and/or execut of correction does not const admission or agreement by the truth of the facts alleged conclusions set forth in the deficiencies. The plan of coprepared and/or executed s	titute the provider of I or statement of rrection is		

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		345323	B. WING			C	
NAME OF D	DOVIDED OD SLIDDLIED	343323	B: Willo _	STREET ADDRESS, CITY, STATE, ZIP	•	/14/2021	
NAME OF PI	ROVIDER OR SUPPLIER						
BRIAN CE	NTRR HEALTH & REHA	BILITATION WALLACE		647 S RAILROAD STREET BOX 966	i .		
				WALLACE, NC 28466			
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F 585	Continued From pag	e 7	F 5	35			
	Record review revea admitted 06/28/2019	led Resident #20 was last		it the required by the provi and state law."	isions of federal		
	dated 01/22/21 indicated cognitively intact and	rly Minimum Data Set (MDS) ated Resident #20 was required extensive tivities of daily living (ADLs).		What corrective action will accomplished for those re have be affected by the de	sidents found to		
	#20's family member 10/29/20. The grieva Receptionist. The Adfollow up on 11/03/20 the grievance as resindicated the investig to the family member evidence of a written to the family member to the family member #20's family member 12/23/20. The grieva Director of Nursing.	evances indicated Resident filed a written grievance on nee was investigated by the dministrator completed the D. The grievance form listed olved on 10/29/2020 and lation findings were reported on 10/29/20. There was no response/summary provided who filed the grievance.  Evances indicated Resident filed a written grievance on nee was investigated by the The Administrator completed 4/20. The grievance form		Per the 2567, the facility fa a written response to griev (Resident # 20) of 3 reside for grievances. The facility contacted the family mem grievance, the family state were all immediately resol written response was need was conducted on 4/7/202 Administrator by the Distri Clinical Services on provious response on all grievance Adverse outcomes were in Element #2	vances for 1 ents reviewed v immediately ber who filed the ed the concerns lived and no ded. Education 21 with the ct Director of ding a written s filed. No		
	listed the grievance a and indicated the inverse reported to the family. There was no eviden response/summary parents who filed the Record review of grie #20's family member 01/18/21. The grieva 01/20/21 by the Adm form listed the grieva 01/20/2021 and indicate the grieva on the record review of grieva on the record recor	as resolved on 12/24/2020 estigation findings were member on 12/24/20. ce of a written provided to the family e grievance.  evances indicated Resident filed a written grievance on nce was investigated on inistrator. The grievance nce as resolved on ated the investigation		All residents have the pote affected by the deficient p What measures will be pu systematic changes made deficient practice does not Element #3  Education was provided b Director of Clinical Service to the Interdisciplinary tea	t into place or to ensure the trecur:  y the District es on 4/8/2021 m on the		
		ed to the family member on s no evidence of a written		Grievance policy and regulation (4)(v) stating that a writter			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	343323	5: 11::10		TREET ADDRESS, CITY, STATE, ZIP CODE	04/	/14/2021
INAIVIE OF F	KOVIDER OR SUFFLIER						
BRIAN CE	NTRR HEALTH & RE	HABILITATION WALLACE			47 S RAILROAD STREET BOX 966		
				V	VALLACE, NC 28466		
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F 585	Continued From page	age 8	F	585			
			'	000			
	member who filed	y provided to the family			be provided to the resident/family who filed the grievance.		
		<b>3</b>			3 3		
		prievances indicated Resident					
		per filed a written grievance on			How the corrective actions will be monitored to ensure the deficient pract	ioo	
		rievance was investigated by on 04/01/2021. The grievance			will not recur, and what quality assurar		
		evance as resolved on			program will be put into place:		
		dicated the investigation			program will be put line place.		
		rted to the family member on			To ensure ongoing compliance, the		
	04/01/21. The doc	umentation revealed the			Administrator and/or designee will		
	•	npleted by the Administrator.			conduct compliance audits weekly x 12	<u>?</u>	
	There was no evid				weeks to ensure a written response is		
		y provided to the family			provided by the facility. The facility will		
	member who filed	the grievance.			provide education on any areas of concern.		
	An interview was o	conducted with the			concern.		
		the District Director of Clinical			The results of the audits will be reporte	:d	
		/2021 at 11:38 AM. The			at the monthly QAPI meeting until such		
	Administrator reve	aled the grievances were			time that substantial compliance has be		
		ated the investigation findings			achieved x 3 months.		
	•	ne family member verbally, but					
		y/documentation had been					
	·	ministrator revealed it had been					
		ntion by her corporate official to be written documentation to			Compliance Date: 4/29/2021		
		s who initiated the grievance.			Compliance Date: 4/29/2021		
	and raminy mornison	o who initiated the ghovanee.					
	In an interview on	04/07/2021 at 2:17 PM, the					
	Administrator state	ed the added comments at the					
		rms was updated. She					
	'	otated the updates after calling					
		members. She explained she					
		ten letters to the family in the					
	tuture and maintaii 	n a copy in the records.					
	In a telephone inte	rview on 04/07/21 at 2:26 PM					
	•	er #1, she revealed she had					
		ten summary from the facility					

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	ROVIDER OR SUPPLIER	BILITATION WALLACE		STREET ADDRESS, CITY, STATE, ZIP CC 647 S RAILROAD STREET BOX 966 WALLACE, NC 28466	)DE	
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F 585	regarding grievances 01/20/21, and 04/01/2 from the facility had of of 04/07/21 to ask if s written summary for h Quality of Care	submitted on 10/29/20, 21. She stated a woman alled her earlier the morning the wanted a copy of the	F 5			4/29/21
SS=D	applies to all treatment facility residents. Bas assessment of a resident residents receive accordance with proferactice, the comprehence plan, and the resident interviews the dressing changes acrea bilateral lower extremity (LLE) Venoreviewed for pressure Findings included:  Resident #50 was addiagnoses of Conges Peripheral Vascular Eminement of Minimum Data Set (Minimum Data Set (Minim	ndamental principle that and care provided to ed on the comprehensive dent, the facility must ensure a treatment and care in essional standards of ensive person-centered sidents' choices.  The is not met as evidenced en, record review, staff and the facility failed to provide cording physician's order for emity (BLE) and a left lower us Ulcer for 1 of 3 residents at ulcers (Resident #50).		"Preparation and/or execution of correction does not const admission or agreement by the truth of the facts alleged conclusions set forth in the sideficiencies. The plan of conprepared and/or executed sit the required by the provision and state law."  What corrective action will be accomplished for those residence have be affected by the definition of the complex	itute the provide or statement o rrection is olely becau- ons of fede e dents found cient practic ervation, dent	er of  of  see ral

OLIVIEI	C . C	MEDIO/ ND CEITTICE				<del></del>	<del>2. 0000 000 1</del>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE	SURVEY
			7 BOILES	_		,	С
		345323	B. WING			1	14/2021
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE		
RDIAN CE	NTRR HEALTH & REHA	BILITATION WALLACE		64	47 S RAILROAD STREET BOX 966		
DINAIN OL	MINN HEALING KENA	BILITATION WALLAGE		W	VALLACE, NC 28466		
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F 684	Continued From page	e 10	F	684			
	venous stasis ulcer o	f the left lower extremity			dressing changes according to physici	an's	
	(LLE) related to (r/t) (	CHF and PVD with			order for a bilateral lower extremity (Bl	-E)	
	interventions to include	de documentation of the			and a left lower extremity (LLE) Venou	s	
	location of wound, an				Ulcer for 1 of 3 residents reviewed for		
	peri-wound area, pair				pressure ulcers (Resident #50). The		
		ırements weekly, evaluate			facility immediately validated that dres	sing	
		h, margins, peri-wound skin,			changes for Resident #50 current,		
	sinuses, undermining	•			completed according to physician orde		
	granulation, infection, necrosis, eschar and				and documented on the treatment reco	ord.	
	• •	progress in wound healing			No Adverse outcomes were identified.		
	on an ongoing basis.		.   _, ,		FI 1/10		
	_	ations as ordered for pain,			Element #2		
		port as needed (PRN) for			An audit was completed on 4/12/2021	to.	
		(s/s) of infection: green edness and swelling, red			An audit was completed on 4/12/2021 ensure all residents with physician ord		
	_	e wound, excessive pain,			for treatments had been completed an		
		prn and weekly treatment			were documented on the treatment	u	
		lude measurement of each			record.		
		wn's width, length, depth,			1000rd.		
		udate and any other notable			What measures will be put into place o	r	
	changes or observati				systematic changes made to ensure the		
					deficient practice does not recur:	-	
	The Treatment Admir	nistration Record (TAR)			•		
		n order for an application of			Element #3		
	an Unna boot to LLE	with vertical rotation for					
	wrapping, on day shif	ft, on every Monday,			On 4/12/2021 current licensed nursing		
	Wednesday and Frida	ay for Vascular Ulcer. The			and licensed agency staff were educat	ed	
	order was dated 01/0	3/2020 and there were			by the Director of Nursing on following		
	missed dates on 01/1	17/2020, 01/24/2020 and			physician orders for treatments and		
	01/27/2020. The orde	er was discontinued			documentation of treatments on the		
	01/30/2020.				treatment record, prior to continuing w		
					Licensed Agency staff and New Licens	ed	
		020 had an order for an			Nursing Hires will be educated on	_	
		a boot to BLE, on day shift,			treatment documentation and following	) of	
		d Thursday for Vascular			physician orders for treatments during	_	
		dated 02/10/2020 and there			orientation by the Director of Nursing of	or	
		n 02/14/2020. The order was			Designee.		
	discontinued 03/03/20	UZU.			Llow the corrective actions will be		
					How the corrective actions will be		1

PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345323	B. WING_		С		
NAME OF D		345323	D. WING _	OTDEET ADDRESS OFFV STATE ZID		4/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
BRIAN CE	NTRR HEALTH & REH	ABILITATION WALLACE		647 S RAILROAD STREET BOX 966	•		
				WALLACE, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LECTION (LECTION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From pag	ge 11	F 68	84			
	application of an Un every Monday for Vadated 03/03/2020 ar on 03/16/2020, 03/2 order was discontinu.  The TAR dated 04/2 application of an Un every Monday for Vadated 03/03/2020 ar on 04/06/2020, 04/1 order was discontinu.  The TAR dated 05/2 application of an Un every Monday for Vadated 03/03/2020 ar dated 03/03/2020 arddated 03/03/2020 ar	020 had an order for an na boot to BLE, on day shift, ascular Ulcer. The order was nd there were missed dates 3/2020 and 04/20/2020. The		monitored to ensure the d will not recur, and what que program will be put into please to ensure ongoing complication of Nursing and/or conduct random complians weekly x 12 weeks to ensure ordered treatments are be and documented on the transfer of the facility will provide edureas of concern.  The results of the audits wat the monthly QAPI meet time that substantial compachieved x 3 months.	pality assurance ace:  ance, the designee will be audits are physician eing completed eatment record, acation on any will be reported ting until such		
	application of an Un every Monday, Wed Vascular Ulcer. The and there was misse 05/18/2020, 05/22/2 The TAR dated 06/2 application of an Un every Monday, Wed Vascular Ulcer. The and there was misse 06/03/2020, 06/05/2 06/15/2020 and 06/2 The TAR dated 07/2 application of an Un	020 had an order for an na boot to BLE, on day shift, nesday and Friday for order was dated 05/12/2020 ed dates on 05/15/2020.  020 had an order for an na boot to BLE, on day shift, nesday and Friday for order was dated 05/12/2020 ed dates on 06/01/2020, 020, 06/10/2020, 06/10/2020, 06/12/2020.  020 had an order for an na boot to BLE, on day shift, nesday and Friday for order was dated 05/12/2020, 020, 06/10/2020, 06/12/2020, 020, 06/10/2020, 06/12/2020.		Compliance Date: 4/29/20	021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345323	B. WING			C 04/14/2021		
	ROVIDER OR SUPPLIER	ABILITATION WALLACE		STREET ADDRESS, CITY, STATE, ZIP COD 647 S RAILROAD STREET BOX 966 WALLACE, NC 28466	•	14/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 684	Continued From page 12 Vascular Ulcer. The order was dated 05/12/2020		F 6	84				
	O7/17/2020.  The TAR dated 08/2 application of an Univery Monday, Wed Vascular Ulcer. The and there was misse 08/28/2020. The ord 08/28/2020.  The TAR dated 09/2 application of an Univery Monday, Wed Vascular Ulcer. The and there was a mis  The TAR dated 11/2 application of an Univery Monday, Wed Vascular Ulcer. The and Univery Monday, Wed Vascular Ulcer. Ther 11/30/2020.	020 had an order for an na boot to BLE, on day shift, nesday and Friday for order was dated 08/31/2020 sed date on 09/04/2020.  020 had an order for an na boot to BLE, on day shift, nesday and Friday for the was a missed date on						
	application of an Uni every Monday, Wed Vascular Ulcer. Ther 12/23/2020. The TAR dated 01/2	020 had an order for an na boot to BLE, on day shift, nesday and Friday for re was a missed date on						
	every Monday, Wed Vascular Ulcer. Ther 01/01/2021, and 01/ During an observatio 04/05/2021 at 8:38 A	na boot to BLE, on day shift, nesday and Friday for re were missed dates on 11/2021. on of Resident #50 on AM, Resident #50 was sitting d his BLE were not wrapped.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		345323	B. WING _			C 4/14/2021		
	ROVIDER OR SUPPLIER	ABILITATION WALLACE		STREET ADDRESS, CITY, STATE, ZIP COD 647 S RAILROAD STREET BOX 966 WALLACE, NC 28466		7/17/2021		
(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 CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 684	04/05/2021 at 4:48 F boot applied to his LI During an observation 04/06/2021 at 9:27 A wheelchair and had I was done at 7:00 PM.  During an interview of 04/05/2021 at 8:38 A Unna boot was removed and would be replaced stated there had been missed his treatment to staff because he know figured they will get to Resident #50 further legs have gotten beto During an interview of (TN) on 04/06/2021 as he was called to the the floor the nurses of treatments but she downked as a treatment but she downked as a treatment but she downked as a treatment but of 101/01 and 01 treatments but didn't	on of Resident #50 on PM, resident did not have Una LE.  on of Resident #50 on PM, resident was in Unna boot to LLE he stated it 1 04/05/2021 on 3-11 shift.  with Resident #50 on PM, Resident #50 stated his eved with his morning bath red soon. Resident #50 also on times when the facility had as and he did not mention it the stated the areas to his lower ter over time.  with the Treatment Nurse at 3:44 PM, the TN stated if a floor and she was working were supposed to do the id her treatments when she int nurse.  with Nurse #1 on 04/06/2021 It stated she had Resident //11/2021 and she did do his document it because she	F6					
	During an interview v 04/06/2021 at 4:20 F	tment nurse doing them. with the Administrator on PM, the Administrator stated staff to follow the orders						

F 684  Continued From page 14  During a telephone interview with the Director of Nursing (DON) on 04/07/2021 at 3:07 PM, the DON stated Nurse #1 stated she did do the treatments that were missing for Resident #50 on 01/1/2021 ard 01/1/1/2021 ard 01/1/2021 ard 01/1/2021 ard 01/1/2021 ard 01/1/2021 ard		DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		PLETED
STREET ADDRESS. CITY, STATE, ZIP CODE			345323	B. WING _				
FREEIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 684  Continued From page 14  During a telephone interview with the Director of Nursing (DON) on 04/72/2021 at 3:07 PM, the DON stated Nurse #1 stated she did do the treatments that were missing for Resident #50 on 01/1/2021 and 01/11/2021. The DON also stated she was not aware of the other missing treatments and her expectations are for the nursing staff to administer treatments and document them when they are done as ordered on the TAR.  F 759  F 759			ABILITATION WALLACE		64	47 S RAILROAD STREET BOX 966	1 04/	14/2021
During a telephone interview with the Director of Nursing (DON) on 04/07/2021 at 3:07 PM, the DON stated Nurse #1 stated she did do the treatments that were missing for Resident #50 on 01/1/2021 and 01/11/2021. The DON also stated she was not aware of the other missing treatments and her expectations are for the nursing staff to administer treatments and document them when they are done as ordered on the TAR.  F 759 Free of Medication Error Rts 5 Pront or More CFR(s): 483.45(f) Medication Errors. The facility must ensure that its-  §483.45(f) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Pharmacy Consultants interviews the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 2 medication errors out of 31 opportunities, resulting in a medication error rate of 6.45% for 2 of 5 sampled residents observed during medication administration. (Resident #47 and Resident #6)  Findings included:  What corrective action will be accomplished for those residents found to	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
1. Resident #47 was admitted 03/13/2020 with diagnoses including Heart Failure, Non-Alzheimer's Dementia and Malnutrition. The quarterly Minimum Data Set (MDS) dated 03/12/2021 had Resident #47 coded as have be affected by the deficient practice: Element #1  Per the 2567, based on observation,	F 759	During a telephone Nursing (DON) on 0 DON stated Nurse # treatments that were 01/1/2021 and 01/1' she was not aware of treatments and her of nursing staff to adm document them who on the TAR. Free of Medication If CFR(s): 483.45(f)(1) §483.45(f) Medication The facility must ension §483.45(f)(1) Medic percent or greater; This REQUIREMEN by: Based on observati Pharmacy Consulta failed to ensure it wa rates greater than 5 medication errors of resulting in a medica of 5 sampled reside medication administ Resident #6)  Findings included:  1. Resident #47 was diagnoses including Non-Alzheimer's De quarterly Minimum II	interview with the Director of 4/07/2021 at 3:07 PM, the stated she did do the emissing for Resident #50 on 1/2021. The DON also stated of the other missing expectations are for the inister treatments and en they are done as ordered error Rts 5 Pront or More on Errors. Sure that its-ation error rates are not 5 T is not met as evidenced ons, record review, staff and ints interviews the facility as free of medication error rate of 6.45% for 2 ints observed during ration. (Resident #47 and stade of the color o			of correction does not constitute admission or agreement by the provide the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely becaute the required by the provisions of federand state law."  What corrective action will be accomplished for those residents found have be affected by the deficient practice.	er of of use eral	4/29/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. DOILDIN		C		
		345323	B. WING			/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	12021	
				647 S RAILROAD STREET BOX 966	,52		
BRIAN CE	NTRR HEALTH & R	EHABILITATION WALLACE		WALLACE, NC 28466			
				· · · · · · · · · · · · · · · · · · ·			
(X4) ID PREFIX TAG	(EACH DEFIC	YY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTI  CROSS-REFERENCED TO TI  DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 759	Continued From	page 15	F 7	759			
		er activities of daily living (ADL).	' '	Consultants interviews, the	facility failed to		
	assistance with h	er activities of daily living (ADL).		ensure it was free of medica	•		
	The care plan dat	ted 01/27/2021 had focus' of		rates greater than 5% as ev			
		formance deficit related to (r/t)		medication errors out of 31	•		
		ie, sometimes, she did not want		resulting in a medication err			
		tivities, take medications, or		6.45% for 2 of 5 sampled re			
	change clothes, has impaired cognitive function			observed during medication			
	or impaired thought processes r/t Dementia.			administration. (Resident #	47 and		
	The facility's medication administration			Resident #6) The facility im	-		
		I June 2008 read in part:		provided education to the lie			
		resident swallows' oral drugs.		observed during medication			
		lications with the resident to		administration on Medicatio			
		nless the resident is approved		Administration and Medicati			
	for self-administra	ation of the medication.		Adverse outcomes were ide	ntified.		
		edication Administration Record		Element # 2			
	, ,	an order for Polyethylene Glycol		All regidents receiving medi	actions have		
		() by giving 17 grams by mouth r Constipation and mix with 8		All residents receiving medi the potential to be affected			
	ounces of juice of	· · · · · · · · · · · · · · · · · · ·		practice.	Jy the delicient		
	ourioes or juice of	water.		practice.			
	_	ation of a medication					
		Resident #47 on 04/07/2021 at		What measures will be put i			
		nt #47 was in her room sitting in		systematic changes made t			
	1	ped. Nurse #1 entered the		deficient practice does not r	ecur.		
		o administer morning h included MiraLAX in 8 ounces		Element #3			
		plained what medications she		Liement #3			
		g and informed Resident #47		On 4/12/2021 current licens	sed nursing		
		X in the cup on her table.		and licensed agency staff w			
Resident #47 took the medication in the sma cup and reached for her MiraLAX. Resident #				by the Director of Nursing o			
				Administration and Medicati			
	•	and put the cup down with ¾ of		Licensed Agency staff and I	New Licensed		
		ft in the cup. Nurse #1 also told		Nursing Hires will be educa			
		did not have to finish the whole		Medication Administration a			
	thing now and lef	t the room.		Errors during orientation by	the Director of		
				Nursing and/or Designee.			
		ew with Nurse #1 on 04/07/2021					
	at 8:28 AM, Nurse	e #1 stated Resident #47 likes to		How the corrective actions	will be		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345323	B. WING				C
NAME OF D	DOVIDED OD CUDDUED	343323	1 2: *******		CTREET ADDRESS SITV STATE ZID SODE	04	1/14/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTRR HEALTH & REI	HABILITATION WALLACE			647 S RAILROAD STREET BOX 966		
					WALLACE, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 759	Continued From page	age 16	f F7	759			
	-	〈 and moved on to another			monitored to ensure the deficient pract	ice	
	resident to begin a				will not recur, and what quality assuran		
	administration.				program will be put into place:		
	During a telephone Consultant (PC) or			Element #4			
	PC stated medicat	ion was supposed to be			To ensure ongoing compliance, the		
	completely adminis			Director of Nursing and/or designee will	II		
	room and should n			conduct random compliance audits			
					weekly x 12 weeks to ensure the facility	•	
		e interview with the Director of			free from Medication error rates greate	r	
	J ,	04/08/2021 at 11:14 AM, the			than 5%. The facility will provide		
	_	ent #47 had not been assessed			education on any areas of concern.		
		nedications. The DON also			The manufacture of the condition will be manufactured.	_1	
		ed that all medications are			The results of the audits will be reporte		
		re leaving a resident's room to be left with the resident to			at the monthly QAPI meeting until such time that substantial compliance has be		
	finish on their own.				achieved x 3 months.	5611	
	iniisii on tiicii owii.	•			achieved x 5 months.		
	During a telephone	e interview with the					
		4/08/2021 at 3:15 PM, the					
		ed her expectations were for					
		olicies and procedures related			Compliance Date: 4/29/2021		
	to medication adm	inistration.					
	0 Decident #6	s admitted 01/12/2020 with					
		g Cerebrovascular Accident					
	•	mer's Dementia, and					
	<b>'</b> ''	ng Cerebral Infarction. Resident					
		everely cognitively impaired					
		sive assistance with his					
		ving (ADL). He was also coded					
		eeding and Feeding tube -					
	nasogastric or abd						
		ed 01/14/2021 had focus' of					
		ormance deficit related to (r/t)					
		ility. He has Altered					
		il) function r/t Dysphagia as					
	evidenced by nothi	ing by mouth status with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345323	B. WING _			C <b>04/14/2021</b>
	ROVIDER OR SUPPLIER	HABILITATION WALLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 647 S RAILROAD STREET BOX 966 WALLACE, NC 28466		04/14/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 759	instillation with revi in part: Discuss and the resident's pract to determine the satto administer, if need compressed tablets mortar and pestle of and mixing with purification (600 MG)/stablet daily.  During an observate endoscopic gastrost administration for Fig. 41 AM, Nurse #1 Resident #6's mediput a Calcium (600 400 IU) tablet in a put the medication was not the pill were stickin medication. Nurse out medication that decarded it in the tip preparing all the mother to Resident #1. During an interview at 9:44 AM, Nurse have been a mistal pieces of medication to decard to the pieces of medication to the pieces of medication that the preparity and the mother to Resident #1.	meet nutrition needs.  dures for enteral tube drug sed date of May 15, 2020 read by unresolved concerns with itioner. Consult the pharmacist afest dosage form of the drug eded. Crush simple is to a fine powder using a or other pill-crushing device rified water.  revealed and order for Vitamin D3 (10 MCG/ 400 IU)  dion of a percutaneous estomy (PEG) tube medication Resident #6 on 04/07/2021 at was observed crushing dications individually. Nurse #1 MG)/Vitamin D3 (10 MCG/ colastic envelope and crushed and a pill crushed, and pieces of g out of the crushed #1 took a spoon and scooped at was not crushed and rash. Nurse #1 finished edications and administered	F7	759		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345323	B. WING _			C / <b>14/2021</b>	
	ROVIDER OR SUPPLIER	BILITATION WALLACE	•	STREET ADDRESS, CITY, STATE, ZIP CODE 647 S RAILROAD STREET BOX 966 WALLACE, NC 28466	, ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 759	but didn't. Nurse #1 fir report that the medica anyone.  During a telephone in Consultant (PC) on OPC stated if the medicand if she knew about the order to a liquid for have been dissolved have been able to be clogging the tubing. Twould expect a call reit should have been reresidents medication because they are expressionally at the property of th	in warm water to dissolve it urther stated she did not ation is hard to crush to  terview with the Pharmacy 4/08/2021 at 9:39 AM, the cation was difficult to crush tit, she could have changed orm. The medication could in warm water and it would administered without the PC also stated she garding the medication, and eported, but parts of a should never be discarded sected to receive the full	F	759			
F 880 SS=E	medication to be disc to crush. Residents a full dosages of medic should have been dis the issue should have During a telephone in Administrator 04/08/2 Administrator stated h	arded because it was hard re expected to receive their ation. The medication solved in warm water and be been reported.  Iterview with the 021 at 3:15 PM, the ner expectations were for ies and procedures related stration.  Control (2)(4)(e)(f)	F	380		4/29/21	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION  NG	(XX	(X3) DATE SURVEY COMPLETED		
		345323	B. WING _			C <b>04/14/2021</b>	
	ROVIDER OR SUPPLIER	BILITATION WALLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 647 S RAILROAD STREET BOX 966 WALLACE, NC 28466	<b>'</b>	04/14/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	infection prevention a designed to provide a comfortable environry development and tradiseases and infection program.  The facility must estand control program a minimum, the follow §483.80(a)(1) A syst reporting, investigating and communicable distaff, volunteers, visi providing services ure arrangement based a conducted according accepted national staff systems of survery possible communication infections before the persons in the facility (ii) When and to who communicable disease reported; (iii) Standard and trato be followed to prevent of the president; including but (A) The type and durity of the provident and the communication in the facility (iii) When and to who communication in the facility (iiiii) Standard and trato be followed to prevent of the president; including but (A) The type and durity of the provident including but (A) The type and durity of the provident including but (A) The type and durity of the provident including but (A) The type and durity of the provident including but (A) The type and durity of the provident including but (A) The type and durity of the provident including but (A) The type and durity of the provident including but (A) The type and durity of the provident including but (A) The type and durity of the provident including but (A) The type and durity of the provident including but (A) The type and durity of the provident including the pr	and control program a safe, sanitary and ment and to help prevent the nsmission of communicable ons.  prevention and control ablish an infection prevention (IPCP) that must include, at wing elements:  em for preventing, identifying, ng, and controlling infections iseases for all residents, tors, and other individuals nder a contractual upon the facility assessment to §483.70(e) and following andards;  In standards, policies, and rogram, which must include, it illance designed to identify ble diseases or y can spread to other y; m possible incidents of se or infections should be msmission-based precautions went spread of infections; olation should be used for a	F8	380			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E SURVEY IPLETED	
		345323	B. WING _		0.	C 4/14/2021
	ROVIDER OR SUPPLIER	ABILITATION WALLACE	,	STREET ADDRESS, CITY, STATE, ZIP CO 647 S RAILROAD STREET BOX 966 WALLACE, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE
F 880	least restrictive pos circumstances.  (v) The circumstance must prohibit emplo disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in or \$483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must har transport linens so a infection.  §483.80(f) Annual rough the facility will concurred in the facility will concurred	nat the isolation should be the sible for the resident under the sible for the resident under the ses under which the facility yees with a communicable skin lesions from direct at or their food, if direct at the disease; and the procedures to be followed direct resident contact.  Stem for recording incidents facility's IPCP and the taken by the facility.  Indie, store, process, and the taken by the spread of the series of the spread of the series of the spread	F	"Preparation and/or executi	on of this plan	
	one of one staff m wore their facial covered nose while working staff members (Diet mask not authorized occurred during a Compact of the conducted on 03/09 provided to all staff	facility staff failed to ensure embers (Dietary Aide #2) vering over their mouth and in the facility and one of one cary Aide #1) wore a cloth d by the facility. The failures cOVID-19 pandemic.  Indicated an in-service was members/departments and see of Personal Protective		of correction does not const admission or agreement by the truth of the facts alleged conclusions set forth in the set deficiencies. The plan of conclusions and/or executed set it the required by the provisi and state law."  What corrective action will be accomplished for those residence affected by the depractice?	the provider of or statement of crection is olely because ons of federal edents found to	

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	14/2021
TO UNE OF TH	TO VIDER OIL OIL OIL I EIER			647 S RAILROAD STREET BOX 966		
BRIAN CE	NTRR HEALTH & REHA	BILITATION WALLACE		WALLACE, NC 28466		
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F 880			F 88	30		
	Equipment (PPE). Ar	nother in-service was also		Element #1: Dietary Aide #1 failed	d to	
		21 on the use of N95 and		follow proper face mask usage wl		
	face shields.			working in the dietary department		
				was wearing a cloth mask.		
	During the initial tour	of the kitchen on 04/05/21,				
	Dietary Aide #1 (DA#	1) was observed wearing a		Element #2: Dietary Aide #2 faile	d to	
	cloth mask.			follow proper face mask usage ar	nd proper	
				face mask placement while exiting	g the	
	During an interview with Dietary Aide #1 on 04/05/21 at 8:02 AM, she explained she could wear the mask and would disinfect it at home and			kitchen to push the dietary cart to		
				resident hall. Her mask was only	•	
				her mouth and not covering her n		
	bring it back. She sta	ated she only used it at work.		A Fishbone/root cause analysis w		
				conducted on 4/28/21 to identify r		
		AM during re-entry to the		cause of the area identified in the		
		#1 had changed to a N95		The Root cause analysis was fac		
	face mask.			by the Administrator, Director of N District Director of Clinical Service	•	
	During an interview w	rith the Dietary Manager		the Infection Preventionist. The F		
	(DM) on 04/05/21 at 9			cause analysis was reviewed with		
		onitored his employees daily		QAPI committee on 4/23/21 & 4/2		
		rotection equipment. He		and incorporated into the facility p		
		ed DA#1 when he arrived		correction below. The Directed P		
		sk was not acceptable for		Correction will be completed by 4	/29/21	
	staff working in the fa	cility. She now had on a		with training conducted by the Dir		
	N95 face mask. He s	stated he would review mask		Nursing and the Infection Prevent	ionist.	
	coverings with all his	staff again.		Element #1 the Dietary Aide use	of a cloth	
				mask had no adverse outcome from	om the	
		ith the Director of Nursing		incident. She was educated imm	•	
	, .	t 1:52 PM, she explained the		by her Manager and Director of N	•	
	-	he surgical mask for all staff		on 4/5/21, and provided with a su	-	
		ng unless you were on the		mask to use at all times while in the	he	
	•	quarantine hall staff would		facility.		
		a face shield for care of		Element #2 Dietary Aide wearing		
		explained cloth masks were		surgical mask only covering her n		] ]
	not permitted or allow			and not her nose while delivering		
		d they receive their guidance		trays had no adverse outcomes fr		
	-	office, the Center for Disease		incident. She was educated imm	-	
	Control, and the Cour	nly Public Health		by the DON on 4/5/21 and immed		
	Department.			properly fixed her surgical mask t	o cover	

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NAME OF D	ROVIDER OR SUPPLIER	343323	1		STREET ADDRESS, CITY, STATE, ZIP CODE	04/	14/2021
NAME OF PI	ROVIDER OR SUPPLIER				, , ,		
BRIAN CE	NTRR HEALTH & REHA	BILITATION WALLACE			47 S RAILROAD STREET BOX 966		
				۷	VALLACE, NC 28466		
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F 880	Continued From pag	e 22	F 8	880			
F 880	During an interview of Nurse (ICN) on 04/06 all staff were trained Personal Protective in placing the facemask She stated all staff in the surgical mask at cloth mask worn by the acceptable. She consisted to the quark a N95 and a face shing She added staff were PPE usage. The ICN following the guideling the Center for Disease Homes and the country 04/06/21 at 4:21 PM, they take the infection and she knew all staff importance of wearing 2. During an observation of the resident homask covering only incovered.  During an interview of 8:24 AM she explaints sometimes and she in She stated she was the	with the Infection Control 6/21 at 4:01 PM she stated on how to don and doff Equipment (PPE), including a over their mouth and nose. The facility should have on a minimal. She stated the he Dietary Aide was not attinued and stated the staff antine unit would be wearing eld along with their full PPEs. The monitored daily regarding and expressed the facility were seen and recommendations of the Control for Nursing ty public health guidance.  With the Administrator on the Administrator stated in control protocols seriously fif were trained and knew the	F 8	880	her nose and mouth. Educated if the mask slips down, she must adjust it immediately to maintain proper face molicy and procedures.  How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:  Element #1 In-service education was provided by the Director of Nursing, SDC/Infection Preventionst beginning 4/5/21 and will be completed by 4/23/2 on proper policies and procedures related to face mask usage and proper placement. A full house audit of all stawas performed and was conducted by Director of Nursing, and Infection Preventionist to ensure all Brian Cente Wallace staff are appropriately wearing surgical face masks and are properly covering their nose and mouth. Multipareas throughout the facility, including dietary department have an abundant supply of surgical face masks for staff usage.  What measures will be put into place to ensure the deficient practice does not reoccur:  Mandatory all staff education on policie and procedures related to face mask usage and proper placement to ensure nose and mouth are covered, and enforcement of no cloth masks to be used in the facility, which includes all	he  11 ted aff the or of ble the	
	it up.	vith the Dietary Manager			Departments (Housekeeping, Laundry, Dietary, Therapy, Maintenance and Nursing. Immediate	,	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
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DDIAN OF	NTDD HEALTH & DE	LARU ITATION WALLACE		647 S	RAILROAD STREET BOX 966			
BRIAN CE	NIRK HEALIH & REI	HABILITATION WALLACE		WAL	LACE, NC 28466			
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F 880	Manager stated he for proper personal DA#2 knew she was facemask over her times. He stated he coverings with all he decoverings with all he decovering an interview of the decovering and the decovering and the decovering and the decovering and the staff were trained placing the facemastated all staff in the surgical mask at a stated the staff assembly with their full PPEs monitored daily recept and the decovering and the	at 9:01 AM, the Dietary monitored his employees daily I protection equipment and as supposed to wear her nose and her mouth at all the lie would review mask his staff again.  I with the Director of Nursing I at 1:52 PM, she explained the g the surgical mask for all staff ding unless you were on the ne quarantine hall staff would and a face shield for care of the explained cloth masks were owed for any staff in the ned they receive their guidance the office, the Center for Disease ounty Public Health  I with the Infection Control (06/21 at 4:01 PM she stated and on how to don and doff the Equipment (PPE), including the Equipment (PPE), including the sk over their noses. She the facility should have on the minimal. She continued and the signed to the quarantine unit the N95 and a face shield along the staff were the grading PPE usage. The ICN lity were following the the ommendations of the Center of for Nursing Homes and the the guidance.	F	E h c h v c c p h v c c p h v v s n n c a e p c tt c T r tt a	education/intervention was provided to Dietary aides #1 & #2 on 4/5/21. Full prouse Education initiated on 4/6/21 at completed 4/23/21. All new hires will provided the mandatory education prior to working on the unit. Daily ongoing observation and education will be provided also to maintain compliance. How the corrective actions will be provided also to maintain compliance. How the corrective actions will be provided also to maintain compliance. Will not recur, and what quality assurated the provided to ensure the deficient practical form will be put into place: Element #1 to ensure ongoing compliance, the Director of Nursing at provided to ensure proper utilization of fourgical face masks on all staff, anonitoring for proper placement over prose and mouth, and monitoring of note of the provided to staff. All new hires/All provided to mathematical process prior to initiating with the results of our auditing process with the provided to monthly QAPI until such the	etice nce and ee x 12 on tely on		
	During an interviev	v with the Administrator on						

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NAME OF PROVIDER OR SUPPLIER  BRIAN CENTRR HEALTH & REHABILITATION WALLACE				STREET ADDRESS, CITY, STATE, ZIP CODE  647 S RAILROAD STREET BOX 966  WALLACE, NC 28466			
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F 880	and she knew all	page 24 action control protocols seriously staff were trained and knew the aring PPE properly.	F	380			