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and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the		· · /	•					
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the								
entities to furnish this information but are still legally responsible for ensuring that the								
legally responsible for ensuring that the								
			-					

Electronically Signed

TITLE

07/29/2021

PRINTED: 07/30/2021

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.

		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 07/30 FORM APPR MB NO. 0938	OVE	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED		
		345386	B. WING _				07/07/202	1	
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE				
WILKES F	REGIONAL MEDICAL CT	R SN			70 WEST D STREET DRTH WILKESBORO, NC 28659				
(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 APF DEFICIENCY)	OULD BE	(X: COMPL DA	ETIO	
F 578	requirements of this s (iv) If an adult individu time of admission and information or articula has executed an adv may give advance dia individual's resident r with State Law. (v) The facility is not r provide this informati or she is able to rece Follow-up procedures the information to the appropriate time. This REQUIREMENT by: Based on record rev Doctor interviews the resident's wishes for status as specified in when Resident #61 w stopped) and the faci Resuscitation (CPR) reviewed. The findings included Resident #61 admitte with diagnoses includ fibrillation, heart block disease. Review of a physician Do Not Resuscitate (Review of admission dated 11/06/20 indica moderately impaired	section are met. ual is incapacitated at the d is unable to receive ate whether or not he or she ance directive, the facility rective information to the representative in accordance relieved of its obligation to on to the individual once he ive such information. Is must be in place to provide individual directly at the T is not met as evidenced iew and staff and Medical facility failed to follow a Do Not Resuscitate (DNR) their advance directives vent into cardiac arrest (heart lity began Cardiopulmonary for 1 of 1 death records d: ed to the facility on 11/04/20 ding heart failure, atrial k and coronary artery n order dated 11/04/20 read;	F 5	578	F578 - Request/Refuse/Disconti CFR: 483.10c (6) (8) (g) (12) (1)-(On 11/8/2020 the incident was a to risk management for review th RL6 reporting system. On 11/11/ staff education was done utilizing algorithm outlining the DNAR Sca Treatment Order process. Inform Technology was made aware of t related to the code status droppit with the LOA ED visit. A manual was implemented immediately for reviewing all patients on LOA and code status upon return. A root of analysis on the incident was also completed in December of 2020. Outcomes of the root cause anal identified the need for reinforced education which was completed, issue with the code status droppit the electronic medical record with visit which had been referred to I and the EPIC build team proceed	(v) reported rough /2020 g a visua ope of nation the issue ng off process r d verifyir cause ysis staff and an ing off of h an ED T. IT	l ig		

Facility ID: 943561

If continuation sheet Page 2 of 11

PRINTED: 07/30/2021

(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES	A. BUILDING	LE CONSTRUCTION	07/07/2021
GIONAL MEDICAL CTF SUMMARY STA (EACH DEFICIENCY	R SN ATEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP CODE	
GIONAL MEDICAL CTF SUMMARY STA (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES			1
SUMMARY STA (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES		1370 WEST D STREET	
(EACH DEFICIENC)			NORTH WILKESBORO, NC 28659	
	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC
part, Nurse Aide (NA) and he was noted to h preathing) "breathing response was called a Resident stopped bre unresponsive at 2238 called and CPR starte	g. "in room to check resident have agonal" (abnormal with oxygen in place, rapid at 2236 (10:36 PM). athing and was (10:38 PM) Code Blue was ed. Shock given at 2243	F 57	research, test, and complete a the electronic medical record to the code status dropping off. was implemented on 7/1/2021 education for the electronic me record process was initiated of and completed on 7/9/21. Pe monitoring will be completed o patients placed on LOA status the ED. 100% of charts will be	o prevent This final fix . Staff edical n 7/1/2021 erformance n all for visits to e reviewed
Doctor (MD) in room to 2245 (10:45 PM) and at that time. Family no by Nurse #1. Nurse #1 was intervie PM. Nurse #1 stated to the night shift from 7: unit. She stated she " event on 11/06/21 but she was sure she was code status but could about the situation as	to assess and called code at pronounced resident dead otified. The note was signed wed on 07/07/21 at 2:16 that she generally worked 00 PM to 7:00 AM on the kind of remembered" the t nothing specific. She stated is aware of Resident #61's recall anything specific to why Resident #61 was		months. Random monitoring w thereafter the 6-monoth period ongoing basis. The Code Stat monitoring will be incorporated QAPI monitoring plan for resid and safety. Data will be report quarterly to the QAPI team. Th for resident Code Status and S Treatment Order will be incorp all new SNF staff orientation	vill occur l on an us l into the ent's rights ted at least he process Scope of
obtained code status was kept on a resider computer. She explain not breathing, the first determine the residen their bracelet and their computer. Again Nurst not recall that far back details about the incid	during report and then it ht's bracelet and in the ned if she found a resident t thing she would do was to ht code status by looking on n verify that by looking in the se #1 stated that she could k and could not speak to any lent.			
	Review of a nurses no part, Nurse Aide (NA) and he was noted to H preathing) "breathing esponse was called a Resident stopped breat inresponsive at 2238 called and CPR started 10:43 PM) for" VFib Doctor (MD) in room f 2245 (10:45 PM) and at that time. Family no by Nurse #1 was intervie PM. Nurse #1 stated the night shift from 7:1 unit. She stated she " event on 11/06/21 but she was sure she was code status but could about the situation as coded. Nurse #1 stated bobtained code status vas kept on a resider computer. She explain to breathing, the first letermine the resider heir bracelet and the computer. Again Nurse to trecall that far back letails about the incide Review of note from t lated 11/06/20 read in emergency departme	Review of a nurses note dated 11/07/20 read in bart, Nurse Aide (NA) "in room to check resident and he was noted to have agonal" (abnormal breathing) "breathing with oxygen in place, rapid esponse was called at 2236 (10:36 PM). Resident stopped breathing and was unresponsive at 2238 (10:38 PM) Code Blue was called and CPR started. Shock given at 2243 10:43 PM) for" VFib (heart quiver). Medical Doctor (MD) in room to assess and called code at 2245 (10:45 PM) and pronounced resident dead at that time. Family notified. The note was signed	Review of a nurses note dated 11/07/20 read in part, Nurse Aide (NA) "in room to check resident and he was noted to have agonal" (abnormal preathing) "breathing with oxygen in place, rapid esponse was called at 2236 (10:36 PM). Resident stopped breathing and was innresponsive at 2238 (10:38 PM) Code Blue was called and CPR started. Shock given at 2243 10:43 PM) for" VFib (heart quiver). Medical Doctor (MD) in room to assess and called code at 2245 (10:45 PM) and pronounced resident dead at that time. Family notified. The note was signed by Nurse #1 was interviewed on 07/07/21 at 2:16 2M. Nurse #1 stated that she generally worked he night shift from 7:00 PM to 7:00 AM on the unit. She stated she "kind of remembered" the event on 11/06/21 but nothing specific. She stated whe was sure she was aware of Resident #61's code status but could recall anything specific about the situation as to why Resident #61 was coded. Nurse #1 stated that generally they obtained code status during report and then it was kept on a resident's bracelet and in the computer. She explained if she found a resident not breathing, the first thing she would do was to letermine the resident code status by looking on heir bracelet and then verify that by looking in the computer. Again Nurse #1 stated that she could not recall that far back and could not speak to any letails about the incident. Review of note from the Medical Doctor (MD) lated 11/06/20 read in part, I was working in the emergency department (ED) "when code blue	Review of a nurses note dated 11/07/20 read in vart, Nurse Aide (NA) "in room to check resident and he was noted to have agonal" (abnormal reathing) "breathing with oxygen in place, rapid esponse was called at 2236 (10:36 PM). Resident stopped breathing and was intresponsive at 2238 (10:38 PM) Code Blue was alaled and CPR started. Shock given at 2243 10:43 PM) for "VFib (heart quiver). Medical Doctor (MD) in room to assess and called code at that time. Family notified. The note was signed by Nurse #1. Surse #1 was interviewed on 07/07/21 at 2:16 PM. Nurse #1 stated that she generally worked he night shift from 7:00 PM to 7:00 AM on the init. She stated she "kind of remembered" the resident studuton as to why Resident #61's soded status but could recail anything specific tbout the situation as to why Resident #61's soded status but could recail anything specific tbout the situation as to why Resident #61's soded status but could recail anything specific tbout the situation as to why Resident #61's soded status but could recail anything specific tbout the situation as to why Resident #61's soded status but could recail anything specific tbout the situation as to why Resident #61's soded status but could recail anything specific tbout the situation as to why Resident #61 was soded. Nurse #1 stated that generally they ubtained code status during report and then it vas kept on a resident's bracelet and in the computer. Again Nurse #1 stated that she could not recall that far back and could not speak to any letails about the incident. Review of note from the Medical Doctor (MD) lated 11/06/20 read in part, I was working in the imergency department (ED) "when code blue

If continuation sheet Page 3 of 11

	CS FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUITIPI	E CONSTRUCTION		<u>O. 0938-039</u> e survey		
	F CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	PLETED		
		345386	B. WING		07	07/07/2021		
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE				
WILKES I	REGIONAL MEDICAL CT	R SN		1370 WEST D STREET NORTH WILKESBORO, NC 28659				
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 578	responded to the cod Cardiopulmonary Re- process. Patient was Respiratory Therapis "Shortly after I arrived showed VFib. Patient unsynchronized at 20 resumed. Nursing the chart indicated he was to have a DNR brace pulse check was perf noted be pulseless. If patient's wishes resu stopped at 2245" (10 hospitalist of the even the family. Signed by The MD was interview The MD explained th on 11/06/20 when a of their protocol, he and responded. The MD stated he did not room as he was assis stated that shortly aft rhythm check which s provided a shock to F with CPR. During this stated he was a DNR member stated oh ye The MD stated when check and Resident a resuscitative efforts w	le. When we arrived suscitation (CPR) was in being bagged by t (RT) without difficulty. d rhythm checked and t was shocked 00 joules and CPR was en notified me that patients as a DNR. Patient then noted let on. At that time another formed, and patient was in accordance with the scitative efforts were :45 PM). I notified the ints and Nursing contacted the MD. wed on 07/07/21 at 3:35 PM. at he was working in the ED code blue was called and per a Nurse from the ER stated that when he entered various staff members iscitate Resident #61. The know any of the staff in the gned to the ER. The MD er he arrived the staff did a	F 578					

Facility ID: 943561

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		<u>D. 0938-039</u> E SURVEY		
	FCORRECTION	IDENTIFICATION NUMBER:	` ´	G	· · ·	PLETED		
		345386	B. WING		07	/07/2021		
NAME OF P	ROVIDER OR SUPPLIER			-				
WILKES F	REGIONAL MEDICAL CT	R SN		1370 WEST D STREET NORTH WILKESBORO, NC 28659				
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 578	have been stopped. I was informed that wh ER earlier that day th erased his code statu issue had since been software company ar transferred from one stayed the same unle including code status The RT was interview The RT confirmed sh #61's code on 11/06/ arrived at the room, i members and they ha actively coding or per #61. The RT stated th the staff had already at some point, during had discussion about someone stated he w the MD arrived aroun when he heard that th code was called, and pronounced deceases she did not recall if R bracelet on or not, sh responsible for airwa chart or look at brace room and the resider coded with CPR in pr The Charge Nurse (C 07/07/21 at 3:56 PM. when Resident #61 w the staff had transfer	He continued to say that he hen Resident #61 went to the he computer software had us. The MD stated that the he corrected with their hd that when a resident was unit to another the orders ess changed by the provider c. wed on 07/07/21 at 3:20 PM. e responded to Resident 20. She stated when she t was full of other staff ad the code cart and were forming CPR on Resident hat at the time she assumed verified his code status but t his code the nursing staff t his code the nursing staff t his code the nursing staff t he same time she did and he resident was a DNR the I Resident #61 was ed by the MD. The RT stated tesident #61 had a DNR he explained she was y and did not generally pull a het when she entered a ht was already being actively rogress. CN) was interviewed on The CN explained that went to the ER on 11/06/21 red him on a leave of hey did that the computer	F 5	78				

Facility ID: 943561

If continuation sheet Page 5 of 11

STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DA	IO. 0938-039 TE SURVEY MPLETED	
	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING				
		345386	B. WING		07/07/2021		
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE			
WILKES I	REGIONAL MEDICAL CTI	R SN		370 WEST D STREET IORTH WILKESBORO, NC 28659			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 578	#61 from the leave of had the provider reen- did not know that it has code status. When Re- cardiac arrest the stat had a DNR bracelet of The CN stated that the department to fix the that time talked to the that time talked to the them a copy of our DI the nurses station. SF Manager placed the i that was electronically continued to discuss shift report so that ev- code status. The CN been corrected and n when a resident was The Nurse Manager (07/07/21 at 11:00 AM Resident #61 had car by the staff and he sh he had a DNR in plac occurred was earlier Resident #61 had a fa his head and was tran Room (ER) for a scar Resident #61 returne later and the staff too absence but unknown had been wiped clear record. The NM expla- began to look at why	a bsence, they should have ther the code status, but they ad been erased and had no esident #61 went into ff coded him even though he on and they should not have. They worked with the IT software issue and during e staff individually and gave NR policy and posted it in the added that the Nurse information on the hot topic y sent out to all staff and we code status during each eryone was aware of the stated that the software had to longer erased any orders placed on leave of absence. (NM) was interviewed on 1. The NM stated that rdiac arrest and was coded tould not have been because the NM stated that what in the day on 11/06/20 all in his room and had hit insferred to the Emergency in of his head. When facility to go to the ER the #61 on a leave of absence. d to the facility a short time k him off the leave of in to them his code status in from the electronic medical ained after the event we that occurred and mething in our software	F 578				

Facility ID: 943561

If continuation sheet Page 6 of 11

	-	D HUMAN SERVICES				FORM): 07/30/2021 // APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345386	B. WING		_	07/	07/2021
NAME OF PF	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
WILKES R	EGIONAL MEDICAL CTF	₹ SN		370 WEST D STREET NORTH WILKESBORO,	NC 28659		
(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 BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 578 F 655	the code status to be did not know that it ne NM stated that they w Technology (IT) to con software version was that corrected the issu was placed on a leave ER) and returned eve with code status and Baseline Care Plan	software was prompting for reentered however the staff eeded to be reentered. The vorked with Information rrect the issue and a new released on July 01, 2021 ue. So now when a resident e of absence (sent to the rything stayed the same nothing was wiped out.	F 578 F 655				8/3/21
SS=D	Planning §483.21(a) Baseline (§483.21(a)(1) The fac implement a baseline that includes the instr effective and person-of that meet professiona The baseline care pla (i) Be developed within admission. (ii) Include the minimum necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (C) Dietary orders. (E) Social services. (F) PASARR recomm §483.21(a)(2) The fac comprehensive care p care plan if the compre-	aive Person-Centered Care Care Plans Fility must develop and care plan for each resident uctions needed to provide centered care of the resident a standards of quality care. I standards of quality care. I standards of quality care. I standards of a resident's m healthcare information care for a resident red to- on admission orders.					

Event ID: CZHO11

Facility ID: 943561

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 07/30/2021 MAPPROVED O. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		345386	B. WING		07	/07/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	•		
	REGIONAL MEDICAL CT			1370 WEST D STREET			
WILKES		(3N		NORTH WILKESBORO, NC 28659			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 655	admission. (ii) Meets the requirer (b) of this section (exc this section). §483.21(a)(3) The far resident and their rep of the baseline care pro- limited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the fac on behalf of the facilit (iv) Any updated infor- of the comprehensive This REQUIREMENT by: Based on observation and staff interviews the baseline care plan for- restrictions (Resident was receiving an anti- for 2 of 6 residents reformed and the The findings included 1. Resident #55 was a 07/01/21 with diagnosishyponatremia (low solid Review of a physiciar fluid restrictions 1500 to hyponatremia. Review of a care plan	ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary plan that includes but is not if the resident. resident's medications and treatments to be acility and personnel acting y. mation based on the details e care plan, as necessary. is not met as evidenced n, record review, resident he facility failed to develop a r a resident on fluid #55) and for a resident that coagulant (Resident #156) viewed for care plans. : admitted to the facility on ses that included dium level). n order dated 07/01/21 read; milliliters (ml) per day due	F 65	5 5 5 5 5 5 5 5 5 5 5 5 5 5	on-Centered I restrictions ere added to ng plans of erbal in SNF staff on of current 7/8/21 to an of care juired tient needs. f care was s contacted an build for agulant ord. for care plan		

Facility ID: 943561

If continuation sheet Page 8 of 11

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 07/30/2021 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		345386	B. WING		0	7/07/2021
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
				1370 WEST D STREET		
WILKES P	WILKES REGIONAL MEDICAL CTR SN			NORTH WILKESBORO, NC 286	559	
(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	(X5) COMPLETION DATE
F 655	Continued From page	e 8	F 6	55		
	No Minimum Data Se available. An observation and in with Resident #55 on Resident #55 was sit her feet elevated. The bed that read; fluid re PM= 1000 ml and fro ml. Resident #55 stat chronically low sodiul drank too much wate level down even lowe at home she drank el helped bring her sodi confirmed that she re to help keep her sodi and was aware Resid restrictions. She was specific care plan for the Charge Nurse (C that Resident #55 ha place but did not kno added or not. The Charge Nurse (C 07/07/21 at 10:33 AM admission nurse was care plan when a res She added that wher comprehensive MDS care plans that were update them as need there was a care plan	et (MDS) information was hterview were conducted 07/06/21 at 10:13 AM. ting up in her chair and had ere was a sign above her estriction 6:00 AM to 6:00 m 6:00 PM to 6:00 AM=500 ted that she had a m level and stated if she r it would bring her sodium er. Resident #55 stated that ectrolyte replacement which um up a little bit. She emained on a fluid restriction um level up. rse #2 on 07/07/21 at 2:42 is familiar with Resident #55 dent #55 was on fluid is unaware if the facility had a fluid restrictions but stated N) would know. She added d a fluid volume care plan in w if fluid restrictions could be CN) was interviewed on 1. The CN stated that the responsible for entering ident admitted to the unit.		was completed on 7/23/21 plans of care for fluid restri anticoagulant therapy wer and initiated on 7/28/21 w to IT for incorporation into care plan system. Effective Performance monitoring of comprehensive plans of c was initiated and will be of the next 6 months. A stap plan of initiation of compre- of care individualized to pa- including for fluid restriction anticoagulant therapy will 8/3/2021. All new resident placed on 100% monitorint months to ensure timely c individualization of resident the additions of fluid restri anticoagulant therapy as a Random monitoring will of the 6-monoth period on an The care plan process will incorporated into the QAP plan with data presented a to the QAPI team. The car will continue to be incorpon new SNF staff orientation.	rictions and re completed ith content sent the electronic ve July 9 2021 of appropriate are per resident ngoing through aff education ehensive plans atient needs ons and be completed by at care plans are og for the next 6 completion and nt need including ctions and applicable. cccur thereafter n ongoing basis. I continue to be PI monitoring at least quarterly are plan process orated into all	

Facility ID: 943561

If continuation sheet Page 9 of 11

PRINTED: 07/30/2021

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		345386	B. WING			07	07/2021
NAME OF P	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
WILKES F	REGIONAL MEDICAL CTI	R SN			1370 WEST D STREET NORTH WILKESBORO, NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 655	from but was not sure restrictions or not, bu 2. Resident #156 was	e if they included fluid t she would look into it. s admitted to the facility on	F	655	5		
	stroke, atrial fibrillatio	ses that included history of n, and hypertension. S's recent admission, a ssessment review was					
	unable to be complete A review of Resident orders revealed an or						
		#156's care plan dated care plan for the use of					
	PM revealed she was and was aware Resid anticoagulation medio the facility had a spec	se #2 on 07/07/21 at 2:42 a familiar with Resident #156 lent #156 was receiving cations. She was unaware if cific anticoagulant and reported the Charge					
	at 3:57PM revealed n entering care plans in medical records and s completed the compr She reported staff mo potential side effects but the facility did not anticoagulant medica	Charge Nurse on 07/07/21 nursing was responsible for to the resident's electronic she verified them when she ehensive assessments. onitor all the residents for of prescribed medications, have a specific tion care plan built into their cord system. She stated					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/30/2021 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345386	B. WING			07/	07/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	REGIONAL MEDICAL CT	R SN			1370 WEST D STREET NORTH WILKESBORO, NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	on anticoagulant med nurses monitored for	residents in the facility are lications and was certain the side effects. She stated she ld create an anticoagulation	F	655			

Event ID: CZHO11

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