PRINTED: 02/14/2022 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345313	B. WING				C
NAME OF D		040010		_	CTREET ADDRESS CITY STATE ZID CODE	1 01/	14/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHAN	IPTON NURSING AND R	EHABILITATION CENTER		1	HWY 305 NORTH		
NOKIII A	III TON NONOINO AND N	ELIABLETATION CENTER		١,	JACKSON, NC 27845		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD B		COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
					DEFICIENCY)		
F 000	INITIAL COMMENTS	i	F	000			
	AI-:4 :4:						
		ation survey was conducted					
		5 complaint allegations were					
		g in deficiencies. Event ID#					
	VHTC11.						
F 657	Care Plan Timing and	d Revision	F	657			2/15/22
SS=D	CFR(s): 483.21(b)(2)	(i)-(iii)					
	§483.21(b) Comprehe	ensive Care Plans					
	§483.21(b)(2) A comp	orehensive care plan must					
	be-						
	(i) Developed within 7	days after completion of					
	the comprehensive as						
		terdisciplinary team, that					
	includes but is not lim	nited to					
	(A) The attending phy	/sician.					
		e with responsibility for the					
	resident.	,					
	(C) A nurse aide with	responsibility for the					
	resident.	,					
		I and nutrition services staff.					
		cticable, the participation of					
		resident's representative(s).					
		be included in a resident's					
		participation of the resident					
	not practicable for the	resentative is determined					
	resident's care plan.	acveropriment of the					
		staff or professionals in					
		ined by the resident's needs					
	•	-					
	or as requested by th	e resident. ised by the interdisciplinary					
	` '						
		ssment, including both the					
	comprehensive and c	quarterry review					
	assessments.	· in making a naddon or d					
	_	is not met as evidenced					
	by:	:			Nambanatan Namina and Data 1997		
	Based on record revi	iew, observations and staff			Northampton Nursing and Rehabilitation	วท	
LABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE
LADUNATURY	DINLUTURO OR PROVIDER/S	JULI LIEN NEFNEJENTALIVE J SIGNATUR	L		IIILE		MUJURIE

02/11/2022

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.

Electronically Signed

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		NSTRUCTION	(X3) DATE	
		345313	B. WING _				C 01/14/2022
NAME OF P	ROVIDER OR SUPPLIER	-1		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
NODTUAL	ADTON NUIDEING AND	DELIABII ITATION CENTED		HWY	305 NORTH		
NORTHAI	IPTON NURSING AND	REHABILITATION CENTER		JAC	KSON, NC 27845		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657	Continued From pag	ge 1	F	657			
	plans for 2 of 4 reside (Resident #1, #2) Findings included: 1. Resident #1 was 9/21/2021, and diag vascular disease an extremity. The care plan dated Resident #1 had act to both lower legs. I evaluate and assess results, observe for and infection and no provide treatment as for venous ulceration healing was dated in revised on 1/2/2022	ty failed to update the care dents reviewed for care plans. admitted to the facility on moses included peripheral dulcerations to the left lower I 9/22/2021 indicated to succerations included to succer weekly and document signs and symptoms of pain offity the physician and to sordered by physician. A goal inside to show positive signs of initiated on 12/23/21 and was a There were no new for the care plan for venous		th the control of the	Center acknowledges receipt of the Statement of Deficiencies and profise Plan of Correction to the extense summary of findings is factual correct and in order to maintain compliance with applicable rules a provisions of quality of care of restricted allegation of compliance. Worthampton Nursing and Rehabit Center response to this Statement Deficiencies does not denote agree with the Statement of Deficiencies does it constitute an admission the deficiency is accurate. Further, worthampton Nursing and Rehabit Center reserves the right to refute the deficiencies on this Statement Deficiencies through Informal Districted any other administrative outlind/or any other administrative or	oposes ent that lly and sidents. ed as a illitation at of eement s nor nat any illitation e any of t of pute ure	
	assessment dated 9 #1 was moderately presence of vascula Physician orders da Resident #1 was ord lymphedema sleeve one hour to decreas Resident #1's woun recommendations in	ted 11/17/2021 revealed dered the application of es to both legs twice a day for se edema.		F C ti a s ii C r ii ii ii F	or 2/8/22, the Facility Consultant ne care plan for resident #1 to rescurately the type and location of tasis ulcers and skin intervention include use of lymphedema sleev on 2/8/22, the Facility Consultant eviewed care plan for resident #2 interventions related to treatment include use of IV antibiotic therap Resident #2 no longer receives IV antibiotic therapy.	t update of venouns to ves. t 2 for of UTI	us

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345313	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	040010	5: 11	STREET ADDRESS, CITY, STATE, ZIF		01/14/2022	_
NAIVIE OF F	ROVIDER OR SUFFLIER				CODE		
NORTHAI	MPTON NURSING ANI	D REHABILITATION CENTER		HWY 305 NORTH			
				JACKSON, NC 27845			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	D.4TE	N
F 657	Continued From pa	age 2	F 6	657			
F 657	Nursing document December 2021 re were not available revealed lymphede Resident #1 lower On 1/14/2022 at 2: observed lying in the applied to both low On 1/14/2022 at 5: MDS Nurse, she s with quarterly and stated the nursing between the quarte based on new orde sleeves arrived at week. On 1/14/2022 at 5: Nurse #2, she stat sleeves were not li plan as an interver stated Resident #1 updated when the lymphedema sleev the order for the ly missed updating R On 1/14/2022 at 5: Director of Nursing access to update t	ation in November 2021 and evealed lymphedema sleeves. Nursing documentation ema sleeves were applied to legs on 1/11/2022. 235 p.m., Resident #1 was bed with lymphedema sleeves ver extremities. 229 p.m. in an interview with the tated she updated care plans annual assessments. She staff updated care plans erly and annual assessments ers, and the lymphedema the facility for Resident #1 this 230 p.m. in an interview with ed the use of the lymphedema sted on Resident #1's care into for venous ulcers. She 's care plan should have been order was written for the ves. She stated she activated imphedema sleeves and desident #1's care plan. 232 p.m. in an interview with the g, she stated all nurses had he care plans and Resident uld had been updated when the	F	On 2/8/22, the Facility Cocompleted an audit of the residents currently receive and/or IV antibiotics. This ensure the resident is call appropriate for use of IV antibiotics. There were not currently receiving IV the antibiotics. On 2/4/22, the Facility Cocan audit of care plans for wounds. This audit is to exare planned for type and wound and skin intervent but not limited to lymphed. The MDS and/or DON with concerns identified during will be completed by 2/15. On 2/8/22, the Director of an in-service with all nurse Care Plans. Emphasis is plan is updated timely an all aspects of resident can not limited to type/locations kin/wound interventions not limited to use of lymphand medications to include to IV therapy/antibiotics. completed by 2/15/22. Af nurse who has not complete in next scheduled work shift nurses will be in-serviced.	e care plan for a ving IV therapy is audit is to be re planned therapy and/or or esidents arapy or IV consultant initiated all residents we ensure resident dema sleeves. Ill address all gethe audit. Audit on ensuring card accurately were to include but the dema sleeved but not limited but the dema sleeved but not limited in-service will be the in-service upon it. All newly hired in service upon it.	ed with the distribution of the distribution o	
		s admitted 12/20/2020 to the sees included dementia and on.		orientation in regards to (The Nurse Supervisor an review care plans for 109	Care Plans.		

	l l	COMPLETED
245242 P. WING		С
345313 B. WING		01/14/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP (HWY 305 NORTH HWY 305 NORTH	CODE	
JACKSON, NC 27845		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTUAL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
Physician orders revealed on 12/13/2021 vascular services was ordered for Resident #2 for intravenous (IV) antibiotics. On 12/14/2021, Ertapenem Sodium Solution one gram intravenously every twenty-four hours for seven days was ordered for Resident #2 for a urinary tract infection. The December 2021 Medication Administration Record (MAR) revealed Resident #2 received IV antibiotics from 12/14/21 to 12/20/2021. The MAR revealed no IV site monitoring or dressing changes. Nursing documentation dated 12/14/2021 revealed vascular services started an intravenous catheter in Resident #2's right arm. On 12/22/2021 nursing documentation revealed the intravenous catheter was intact and the completion of intravenous antibiotics. The annual Minimum Data Set (MDS) assessment dated 12/13/2021 indicated Resident #2 was at risk for recurrent urinary tract infections and interventions included to administer medication as ordered by the physician. There was no plan of care for intravenous therapy on the care plan dated 11/2022 or the previous care plan dated 10/4/2021. On 1/14/2022 at 4:43 p.m. in an interview with Nurse #1, she stated she removed the IV catheter on 12/27/2021 and did not document the removal of the IV catheter in Resident #2's electronic medical record.	onth utilizing the audit is to addit is to addit is to additional the wounds to wounds, or include but edema sleeves erapy and/or IV nurse, Nurse are and MDS terns identified updating care staff. The view and initial veekly x 4 week ensure all all forward the audit Tool to the ce Performance mittee monthly e QA Committee the and review of determine may need to place and to	is a second of the second of t

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG	((X3) DATE SURVEY COMPLETED
		345313	B. WING _			C 01/14/2022
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE HWY 305 NORTH JACKSON, NC 27845		VIII-WASAL
(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 CORRECT ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APPLICATION CONTROL OF	HOULD BE	DATE
F 657	MDS nurse, she state with the scheduled quassessments, and nubased on orders betwassessments. She stated therapy was not included 12/23/2021 because her IV therapy prior trassessment On 1/14/2022 at 5:43 Nurse #2, she stated on Resident #2's care activated the order for 12/13/2021 and should plan. On 1/14/2022 at 5:45 Director of Nursing, supdated quarterly, and plans or resident's care plans there was a new order Quality of Care CFR(s): 483.25 § 483.25 Quality of Care CFR(s): 483.25 § 483.25 Quality of care is a fuapplies to all treatmer facility residents. Bas assessment of a residents received accordance with profipractice, the comprehence of	p.m. in an interview with the ed she updated care plans uarterly and annual MDS urses updated the care plans ween the scheduled MDS ated intravenous (IV) ided on the care plan after Resident #2 had completed to 12/23/2021 MDS B p.m. in an interview with IV therapy was not included to plan. She stated she or the IV therapy on all have updated the care plans were included an an interview with the she stated care plans were included and when treatment to indition changed. She stated should be updated when the for IV therapy. B p.m. in an interview with the she stated care plans were included the care included the care updated when the for IV therapy. B p.m. in an interview with the she stated care plans were included to she updated when the for IV therapy.	F 6			2/15/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP		
		345313	B. WING _			01/	14/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
NODTHAN	ADTON NUIDEING AND I	REHABILITATION CENTER		Н	WY 305 NORTH			
NORTHAI	IPTON NURSING AND I	REHABILITATION CENTER		J	ACKSON, NC 27845			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL 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 684	Continued From pag	e 5	F	684				
		view and staff interviews, the			F684 Quality of Care			
	facility failed to document weekly skin assessments on vascular wounds that included staging, measurements, drainage, pain, and assessment of the wound bed and surrounding tissue for 1 of 1 resident reviewed for wound				On 1/17/22, the Director of Nursing assessed resident #1 bilateral venous stasis ulcers to include measurements			
		lent reviewed for wound			and description of the wound bed and			
	care. (Resident #1)				surrounding tissue, treatment and			
	F				notification of the physician and resider			
	Finding included:				representative with documentation in the electronic record.	ie		
		nitted to the facility on						
		oses included peripheral			On 1/15/22, the assigned hall nurses			
	extremity.	d ulcerations to the left lower			initiated a 100% skin audit of all residents. This audit was to identify any resident with			
	extremity.				skin/wound concerns and to ensure	/VIUI		
	The care plan dated	9/22/2021 indicated			resident was assessed per facility proto	ocol		
	•	ual venous stasis ulcerations			to include staging, measurements and	,,,,		
	to both lower legs, a	nd interventions included			description of the wound bed and			
	documenting weekly				surrounding tissue, treatment initiated a	and		
	assessments of the	ulcerations.			notification of the physician and resider	nt		
					representative with documentation in the			
	The admission Minin	, ,			electronic record. The Director of Nursi	•		
		/27/2021 indicated Resident			will address all concerns identified duri	ng		
	_	ognitively impaired, required of one person with his			the audit to include assessment of the resident to include location of the woun	nd		
		ig except for eating and			staging when indicated, measurements			
	_	d the presence of vascular			and description of the wound bed and	'		
	ulcerations.	a the precence of vaccaia.			surround tissue, treatment initiated,			
					notification of the physician and resider	nt		
	Resident #1's wound	l assessment dated			representative with documentation in the			
	, .,	three vascular wounds on the			electronic record. Audit will be complete	ed		
		and two vascular wounds on			by 2/15/22.			
		ity. The wound assessment			0 0/4/00 11 5 1111 0 11 11 11			
		ents for each vascular wound			On 2/4/22, the Facility Consultant initia			
		ed wound bed with an			an audit Wound Ulcer Assessments of			
		sanguinous drainage. There nd assessments documented			residents with wounds. This audit was ensure Wound Ulcer Assessment was	เด		
		tronic medical record from			completed per facility protocol with to			
	12/8/221 to 1/14/202				include staging, measurements and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345313	B. WING _			1	C 14/2022	
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	1-1/2-22	
				н	WY 305 NORTH			
NORTHAN	IPTON NURSING AND	REHABILITATION CENTER			ACKSON, NC 27845			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	both legs of Resided drainage that was fill was called, and Resantibiotics and was clinic on 12/21/202. On 1/14/2022 at 12 Nurse #1, she stated wound nurse for the stated wound assess weekly on Wedness been able to assess weeks because she medication cart. She was performing the On 1/14/22 at 4:19 former Director of Nassessments were Wednesday weekly wound nurse was a wound assessment nurse was not avail been delegated to assessments. On 1/14/2022 at 4:50 Director of Nursing, was to evaluate the	rsing documentation revealed ant #1 were red, swollen and oul smelling. The physician sident#1 was started on scheduled for the wound care 1. :38 p.m. in an interview with ed she had served as the erfacility until 1/12/2022. She assments were scheduled days and stated she had not as the wounds for the last four erwas assigned to a re stated she did not know who assessments. p.m. in an interview with the dursing, she stated the wound conducted on Tuesday or any by the wound nurse, and the available to complete the services. She stated if the wound able, another nurse would had conduct the weekly wound sond the stated the wound nurse would sond the wound services with the she stated the wound nurse wounds weekly and bund assessment in the	F	684	description of the wound bed and surrounding tissue, treatment initiated notification of the physician and reside representative with documentation in the electronic record. The DON will address all concerns identified during the audit include completing assessment per fact protocol with documentation in the electronic record to include staging whindicated, measurements and descript of the wound bed and surrounding tiss treatment initiated and notification of the physician and resident representative. Audit will be completed by 2/15/22. On 1/17/22, the facility consultant initiation in-service with all nurses in regards Wound Process with emphasis on skin referrals, assessment of wounds to include staging, measurements and description of wound bed and surround areas, wound treatment protocols, notification of MD/RR and updating carplans. In-service will be completed by 2/15/22. After 2/15/22, any nurse who has not completed the in-service will complete in-service upon next schedul work shift. All newly hired nurses will be in-serviced during orientation in regard Wound Process. The Director of Nursing will review 10% residents with wounds to include residual tilizing the Wound Care Audit Tool weekly x 4 weeks then monthly x 1 more and the process.	ent the ses to cility en ion ue, ne ding re led se to se de les to worth.		
					This audit is to ensure all wounds have been assessed per facility protocol with documentation in the Wound Ulcer Flowsheet, initiation of treatment per	e		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION		PLETED
		345313	B. WING _			l	C / 14/2022
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		HW	REET ADDRESS, CITY, STATE, ZIP CODE VY 305 NORTH ICKSON, NC 27845	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
		al Fluids. t be administered consistent ndards of practice and in		694	wound protocol or MD orders, updating care plan and that the MD/RR were notified of wound status. The Director of Nursing will address all areas of concertidentified during the audit to include assessing resident, initiating treatment MD orders or wound protocol, completi assessments, updating care plan and notification of MD/RR. The Administrate will review and initial the Wound Care Audit Tool weekly x 4 weeks to ensure areas of concern were addressed. Administrator will forward the Wound Caudit Tool to the Executive QAPI Committee monthly x 2 months. The Executive QAPI Committee will review Wound Care Audit Tool monthly x 2 months to determine trends and / or issues that may need further interventic put into place and to determine the need for further and / or frequency of monitoring.	of rn per ng or all are	2/15/22
	the resident's goals a This REQUIREMENT by: Based record review facility failed to remove catheter after intravel	on-centered care plan, and and preferences. is not met as evidenced and staff interviews, the we a peripheral intravenous therapy was completed eviewed for intravenous (IV)			F694 Parenteral/IV Fluids On 12/27/21, the assigned nurse discontinued IV access for resident #2	per	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345313	B. WING		C 01/14/2022
NAME OF P	ROVIDER OR SUPPLIER	0.00.0		STREET ADDRESS, CITY, STATE, ZIP CODE	01/14/2022
TO UNE OF TH	TO VIDEIT OIT OOI I EIEIT			HWY 305 NORTH	
NORTHAN	IPTON NURSING AND R	EHABILITATION CENTER		JACKSON, NC 27845	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475
F 694	Continued From page	e 8	F 694	4	
	therapy. (Resident #2	2)		physician order.	
	Findings included:			On 1/17/22, the Director of Nursing completed an audit of all orders for IV	
	The facility's "Remova			therapy to include IV antibiotics for the	
		dated 1/2008 stated a		past 30 days. This audit was to ensure	
		moved when therapy was		access was discontinued upon comple	
		utine site rotation and when plications was suspected.		of IV therapy/antibiotic as directed by the physician. The Director of Nursing and	
	Contamination of Com	plications was suspected.		assigned hall nurse will address all	'
	Resident #2 was adm	nitted 12/20/2020 to the		concerns identified during the audit to	
		s included dementia and		include clarifying IV therapy orders wh	en
	urinary tract infection.			indicated for stop date and discontinui	
	,,			IV access as directed by the physician	
	Physician orders reve	ealed on 12/13/2021			
	-	s ordered for Resident #2 for		On 1/17/22, the Director of Nursing	
	intravenous antibiotic	s. On 12/14/2021,		initiated an in-service with all nurses in	1
	Ertapenem Sodium S	olution one gram		regards to Intravenous Therapy with	
	intravenously every to	venty four hours for seven		emphasis on removing IV catheter after	er IV
	days was ordered for	Resident #2 for a urinary		therapy/antibiotics completed as direct	ted
	tract infection.			by the physician and/or clarification of	
				physician order when indicated to inclu	
		Medication Administration		a stop date. In-service will be complete	
	, ,	ed Resident #2 received IV		by 2/15/22. After 2/15/22, any nurse w	ho
	antibiotics from 12/14	/21 to 12/20/2021.		has not completed the in-service will	
	N	1.1.140/00/0004		complete in-service upon next schedu	
	Nursing documentation			work shift. All newly hired nurses will be	
		ous catheter was intact and		in-serviced during orientation in regard	is to
		s was completed. There		Intravenous Therapy.	
	the intravenous cathe	mentation indicating when		The Minimum Data Set Nurse will aud	it all
	uno muavemous calme	tor was removed.		residents with newly written IV	it all
	The annual Minimum	Data Set (MDS)		therapy/antibiotic orders utilizing the	
		/23/2021 indicated Resident		Intravenous Therapy Audit Tool weekly	/ x 4
	#2 received antibiotics			weeks then monthly x 1 month. This a	
	intravenous therapy.	,		is to ensure IV therapy/antibiotics was	
				administered per physician order and	
	The care plan dated 1	1/12/2022 revealed Resident		access was discontinued upon comple	
		urrent urinary tract infections		of IV therapy/antibiotic as directed by	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF PE	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE	01/	14/2022
					WY 305 NORTH		
NORTHAN	IPTON NURSING AND R	EHABILITATION CENTER			ACKSON, NC 27845		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 694	Continued From page	9	F 6	694			
	was no plan of care for the care plan dated 1 care plan dated 10/4/ On 1/14/2022 at 4:43 Nurse #1, she stated nurse when Resident intravenous antibiotic catheters were discord and did not know why been removed. Nurse IV catheter on 12/27/2 the removal of the IV electronic medical received the IV catheter was not always removed. Nurse IV catheter was not catheter was not catheter was removed. On 1/14/2021 at 4:50 Director of Nursing, s	d by the physician. There or intravenous therapy on /12/2022 or the previous 2021. p.m. in an interview with she was not the assigned #2 completed her s. She stated intravenous attinued at the end of therapy of the IV catheter had not e #1 stated she removed the 2021 and did not document catheter in Resident #2's cord. She stated the site of ot red or swollen when the			physician. The MDS nurse and Nurse Supervisor will address all concerns identified during the audit to include clarification of physician to include stop date, removing IV access when indicat and re-training of staff. The DON will review and initial the Intravenous Thera Audit Tool weekly x 4 weeks then mont x 1 month to ensure all concerns were addressed. DON will forward the Intravenous Thera Audit Tool to the Executive QAPI Committee monthly x 2 months. The Executive QAPI Committee will review Intravenous Therapy Audit Tool monthl 2 months to determine trends and / or issues that may need further interventing put into place and to determine the need for further and / or frequency of monitoring.	ed apy thly apy y x ons	
F 842 SS=B	Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not re- resident-identifiable to (ii) The facility may re- resident-identifiable to accordance with a co- agrees not to use or co-	dentifiable Information 483.70(i)(1)-(5) Int-identifiable information. elease information that is to the public. elease information that is of an agent only in entract under which the agent disclose the information ene facility itself is permitted	F 8	342			2/15/22
		s and practices, the facility					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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NAME OF D	20//055 05 01/05/155	345313	D. WING _	OTDE	T ADDRESS OF STATE 71D SODE	01/	14/2022
NAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
NORTHAN	IPTON NURSING AND R	EHABILITATION CENTER		HWY 305 NORTH JACKSON, NC 27845			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	must maintain medicathat are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The fact all information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permit with 45 CFR 164.506 (iv) For public health a neglect, or domestic vactivities, judicial and law enforcement purp purposes, research p medical examiners, for	ented; e; and ganized lility must keep confidential ned in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance	F	342			
	§483.70(i)(3) The factorecord information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirements.	ars after a resident reaches					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345313	B. WING _				C 14/2022
	ROVIDER OR SUPPLIER IPTON NURSING AND F	EHABILITATION CENTER		HW	REET ADDRESS, CITY, STATE, ZIP CODE Y 305 NORTH CKSON, NC 27845	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	§483.70(i)(5) The me (i) Sufficient informati (ii) A record of the res (iii) The comprehensi provided; (iv) The results of any and resident review of determinations condu (v) Physician's, nurse professional's progre (vi) Laboratory, radio services reports as re This REQUIREMENT by: Based on record rev staff interview, the fad document the applica as physician ordered sleeves were not ava resident. (Resident # Findings included: Resident #1 was adn 9/21/2021. His diagni vascular disease and extremity. The care plan dated of Resident #1 had actu to both lower legs, ar treatments as ordere The admission Minim assessment dated 9/ #1 was moderately of presence of vascular	dical record must contain- on to identify the resident; sident's assessments; ve plan of care and services / preadmission screening evaluations and loted by the State; l's, and other licensed ss notes; and logy and other diagnostic equired under §483.50. is not met as evidenced liew, resident interview and cility failed to accurately ation of lymphedema sleeves when the lymphedema ilable in the facility for 1 of 1 1) nitted to the facility on loses included peripheral ulcerations to the left lower 0/22/2021 indicated al venous stasis ulcerations and interventions included d by the physician. lum Data Set (MDS) 27/2021 indicated Resident lognitively impaired and the	F		F842 Resident Records-Identifiable Information On 1/31/22, the Director of Nursing reviewed Treatment Administration Record (TAR) for resident #1 from 1/17/22-1/31/22 to ensure Lympheden sleeves applied per physician order ar documented accurately on the TAR. Nother concerns identified. On 1/27/22, the Director of Nursing initiated an audit of all treatment orders include but not limited to lymphedema sleeves. This audit is to ensure the fact had appropriate treatment supplies available to complete treatments per physician orders. The DON will address all concerns identified during the audit include obtaining supplies as indicated notification of the physician for further instructions when supplies are not available. Audit will be completed by 2/15/22. On 2/3/22, the Director of Nursing initial an audit of all current orders for reside	d o s to ility s to or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
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		345313	B. WING _			01/14/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
				HWY 305 NORTH			
NORTHAI	MPTON NURSING AND	REHABILITATION CENTER		JACKSON, NC 27845			
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F 842	Continued From page 12		F 8	342			
	order for the application of lymphedema sleeves for Resident #1 to both legs twice a day for one hour to decrease edema. There was no order to			attending wound clinic. ensure the facility is foll recommendations in re	lowing wound clinion gards to		
	hold lymphedema s Nursing documenta	sleeves for Resident #1.		treatments and wound in DON will address all conduring audit to include of	ncerns identified		
	lymphedema sleeve facility in Novembe	es were not available in the r 2021 and December 2021. ation revealed on 12/21/2021,		when indicated. Audit w 2/15/22.		у	
	the physician held a sleeves for Resider	application for lymphedema nt #1 until lymphedema		On 2/8/22, the Facility (completed an audit of T	AR from		
	sleeves were availa	able.		2/1/22-2/7/22. This aud treatment not complete order or documented ac	d per physician		
	Record (TAR) indic	ated lymphedema sleeves dered twice a day for thirteen		provided. The DON will concerns identified duri	address all		
	once a day on four	ys out of the first twenty days of December and include assessment of the residuce a day on four days of the first twenty days in notification of the physician of the		cian of the			
		ember 21, 2021, the MAR for lymphedema sleeves was s.		physician and/or educa will be completed by 2/	15/22.		
	indicated lymphede at the facility and u when nursing docu	ation for January 2022 ema sleeves were unavailable ntil 1/11/2022 at 6:00 p.m. mentation revealed es were applied to Resident		On 1/17/22, the Directo initiated an in-service w regards to TAR Docume emphasis on ensuring t documentation of treatr completed and/or notific physician for further ins supplies are not available.	vith all staff in entation with timely and accurate ments when cation of the structions when	Э	
	lymphedema sleev first eleven days in lymphedema sleev	TAR for Resident #1 recorded es were applied six days of the January 2022 when the es were not available.		be completed by 2/15/2 any nurse who has not in-service will complete next scheduled work sh nurses will be in-service	22. After 2/15/22, completed the in-service upon hift. All newly hired ed during		
	Nurse #1, she state sleeves were not a December 2021 an	08 p.m. in an interview with ed Resident #1's lymphedema vailable at the facility in d arrived at the facility last he documented on the		orientation in regards to Documentation. The IDT team to include Administrator, Charge N	e MDS nurse,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345313	B. WING			C I/ 14/2022	
NAME OF P	ROVIDER OR SUPPLIER	0.00.0	 	STREET ADDRESS, CITY, STATE, ZIP (1/14/2022	
NAME OF PROVIDER OR SUPPLIER NORTHAMPTON NURSING AND REHABILITATION CENTER				HWY 305 NORTH	OODL		
			JACKSON, NC 27845				
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(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 APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE			
F 842	Continued From page	nued From page 13 F 842					
r 842	December 2021 TAR applied as ordered w sleeves were not ava #1. She stated she do sleeves were applied documented lympher She stated the Direct nursing staff applicatic could not be docume received to hold the alymphedema sleeves. On 1/14/2022 at 2:35 Resident #1, he state arrived at the facility on he had been wearing every day since Tues. On 1/14/2022 at 3:40 central supply manage was not able to locate lymphedema sleeves the lymphedema sleeves the lymphedema sleeves.	lymphedema sleeves were hen the lymphedema ilable to apply to Resident ocumented the lymphedema because other nurses had dema sleeves were applied. Or of Nursing informed the on of lymphedema sleeves inted, and an order was application of the or in an interview with the definition of the lymphedema sleeves on Monday 1/10/2022, and the lymphedema sleeves iday 1/11/2022.	F 8	Facilitator will review TAR 5 times a week x 4 weeks 1 month utilizing the TAR A Report. This audit is to ensure completed per physicial accurate documentation of MDS nurse, Charge Nurse Facilitator will address all didentified during the audit if assessment of the resident treatment as ordered, notified physician and/or re-trainin DON will review and initial Administration Report 5 times weeks then monthly x 1 mall concerns were address. The Staff Facilitator will audorders weekly x 4 weeks the month utilizing the TAR Sunth audit is to ensure the appropriate treatment supplied to complete treatments pedorders. The Staff Facilitator will audorders. The Staff Facilitator will audorders weekly x 4 weeks the propriate treatment supplied to complete treatments pedorders. The Staff Facilitator will audorders.	then monthly x Administration sure treatments an order with in the TAR. The e and/or Staff concerns to include it, completion of fication of the g of staff. The the TAR mes a week x 4 onth to ensure ed. idit treatment hen monthly x 1 ipply Audit Tool. facility had plies available r physician		
	_	act date on the arrival of the		Nurse will address all cond during the audit to include supplies or notification of p	cerns identified ordering ohysician for		
	former Director of Nu was not aware the far lymphedema sleeves learning Resident #1 sleeves available at t indicated nursing doc lymphedema sleeves on documentation of She stated nursing st	p.m. in an interview with the rsing (DON), she stated she cility was not able to receive for Resident #1. Upon did not have lymphedema he facility and the TAR sumentation of application of s, she conducted in-services care with the nursing staff. aff cannot document n when it was not provided.		further instructions when savailable. The DON will re Supply Audit Tool weekly amonthly x 1 month to ensuaddressed. DON will forward the TAR Report and TAR Supply Audit Tool months. The Executive QA will review TAR Administra TAR Supply Audit Tool momonths to determine trend	Administration udit Tool to the e monthly x 2 API Committee attion Report and nthly x 2		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345313	B. WING _			C 01/14/2022	
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NODTUAL	ADTON NUIDOING AND D	ELIABII ITATION OFNITED		HWY 305 NORTH			
NORTHAI	IPTON NURSING AND R	EHABILITATION CENTER		JACKSON, NC 27845			
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F 842	On 1/14/2022 at 4:50 DON, she stated reside on the Medication Ada and Treatment Admin stated codes were av MAR and TAR why reas ordered and nurse in the nurse notes als	p.m. in an interview with the dent care was documented ministration Record (MAR) istration Record (TAR). She ailable to document on the sident care was not given s could document reasons o. She stated nursing staff resident care as given on	F8	issues that may need further put into place and to determ for further and / or frequency monitoring.	nine the nee		