	MEDICAID SERVICES				RM APPROVE 10. 0938-039	
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
345436		B. WING			R-C 5/10/2022	
ROVIDER OR SUPPLIER	1	ST	TREET ADDRESS, CITY, STATE, ZIP COD			
TON REHABILITATION A	ND HEALTHCARE					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLETION DATE	
Initial Comments		E 000				
conducted on 5/9//22 E- 0001 was correcte	through 5/10/22. The tag d as of 4/25/22.	{F 000}				
through 5/10/22. Tag S/S of C (level A defic into substantial comp Qualifications of Activ	F680 was re-cited with a ciency). The facility is back liance effective 5/10/22. vity Professional	{F 680}				
directed by a qualified qualified therapeutic r activities professional (i) Is licensed or regis State in which practic	d professional who is a recreation specialist or an who- tered, if applicable, by the					
 (A) Eligible for certific recreation specialist of professional by a reco or after October 1, 19 (B) Has 2 years of ex 	or as an activities ognized accrediting body on 90; or operience in a social or					
of which was full-time program; or (C) Is a qualified occu occupational therapy	in a therapeutic activities upational therapist or assistant; or					
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Based on record revi facility failed to ensur	e the activities program was					
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Initial Comments An unannounced ons conducted on 5/9//22 E- 0001 was correcte INITIAL COMMENTS An onsite revisit was through 5/10/22. Tag S/S of C (level A defice into substantial comp Qualifications of Activ CFR(s): 483.24(c)(2) §483.24(c)(2) The activities professional (i) Is licensed or regis State in which practice (ii) Is: (A) Eligible for certifice recreation specialist of professional by a reco or after October 1, 19 (B) Has 2 years of ex- recreational program of which was full-time program; or (C) Is a qualified occu occupational therapy (D) Has completed a the State. This REQUIREMENT by: Based on record revi facility failed to ensur- directed by a qualified activities director.	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Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure the activities program was directed by a qualified professional for 1 of 1 activities director.	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Initial Comments E 000 An unannounced onsite revisit survey was conducted on 5/9//22 through 5/10/22. The tag E- 0001 was corrected as of 4/25/22. INITIAL COMMENTS F 000} An onsite revisit was conducted on 5/9/22 through 5/10/22. Tag F680 was re-cited with a S/S of C (level A deficiency). The facility is back into substantial compliance effective 5/10/22. 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Electronically Signed

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.

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An interview conducted on 5/10/2022 at 4:05 P.M.								
with the Administrator and the Regional Director			-					
of Clinical Services revealed the AD was hired to work under the supervision of an AD at a sister		-						

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 05/13/2022

		ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345436			B. WING			R-C 05/10/2022	
NAME OF PROVIDER OR SUPPLIER WELLINGTON REHABILITATION AND HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 TANDAL PLACE KNIGHTDALE, NC 27545			
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 680}	facility until she succe Activities Director Pro May 9, 2022. During Director of Clinical Se hired AD had not wor		{F 6	580}			

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If continuation sheet Page 3 of 3

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