	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345392	B. WING		05/18/2023
NAME OF PR	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	
				2051 COUNTRY CLUB ROAD	
WADESBO	ORO HEALTH & REHA	AB CENTER		WADESBORO, NC 28170	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
E 000	Initial Comments		E 00		
F 000	conducted on 05/1	ent ID # AHKN11.	F 00	5	
E 641	conducted from 05 Event ID# AHKN11		F 64		6/9/23
F 64 I SS=D	Accuracy of Assess CFR(s): 483.20(g)	sments	F 64		6/9/23
	The assessment m resident's status.	cy of Assessments. hust accurately reflect the NT is not met as evidenced			
	Based on record refacility failed to acc Data Set (MDS) as	eview and staff interview, the surately code the Minimum sessments for 4 of 16 whose MDS were reviewed , #55 & # 60).		Preparation and submission of this pl of correction by Wadesboro Health & Rehabilitation does not constitute an admission or agreement by the provid the truth of the facts alleged or the correctness of the conclusions set for	ler of
	Findings included:			on the statement of deficiencies. The of correction is prepared and submitte	plan
	1. Resident # 31 w 10/13/22.	as admitted to the facility on		solely pursuant to the requirements un state and federal laws.	
	2/21/23 for Seroqu medication) 100 m	a physician's order dated el (an antipsychotic illigrams (mgs.) give 1 tablet by ay for dementia with psychosis.		F641 1. Address how the corrective action to be accomplished for those residents found to have been affected by the deficient practice:	
		a physician's order dated the Seroquel to 100 mgs - outh 3 times a day		1a. Resident #60 had a modification of on 5/25/23 that accurately reflects his disposition on discharge. Submitted o	

**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.

06/08/2023

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		<u>NO. 0938-03</u> ATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,			OMPLETED	
		345392	B. WING			05/18/2023	
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP COD	E		
WADESBO	ORO HEALTH & REHAB	CENTER		2051 COUNTRY CLUB ROAD WADESBORO, NC 28170			
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
F 641	Continued From pag	e 1	F 64	1			
				5/25/23.			
	The significant chang	ge in status MDS		1b.Resdient #9 had a modific	ation on the		
		/3/23 indicated that Resident		Brief Interview for mental stat	us (BIMS)		
		antipsychotic medication		on 5/30/23 and was submitte			
	-	nt period and a gradual dose		1c. Resident #55 had a new I			
		the antipsychotic medication		Data Set assessment comple			
	had not been attemp	ted.		5/24/23 that accurately reflec	ts sections C		
				and D.	<b>G 4</b> :		
		nterviewed on 5/17/23 at Nurse had reviewed the		1d. Resident #31 had a modi completed and submitted by			
		r the Seroquel and verified		Data Set Nurse on May 31, 2			
		attempted. She indicated		accurately reflecting the Grac			
		for the GDR and she would		Reduction.			
	complete a correction			2. Address how the facility wi	ll identify		
				other residents having the po			
	The Director of Nursi	ng (DON) was interviewed		affected by the same deficien	t practice.		
		AM. The DON stated she		2a. The administrator contact	the		
	expected the MDS as	ssessments to be accurate.		Regional Clinical Reimburser			
				Specialist (RCRS) on 5/19/23			
		admitted to the facility on		audit of all Minimum Date Se	. ,		
	3/9/23.			assessments beginning from	January 1,		
	The eignificent cheme	no in status Minimum Data		2023 to current.	mburgeneent		
		ge in status Minimum Data ent dated 4/26/23 indicated		2b. The Regional Clinical Rei Specialist completed a 100%			
		is and mood sections were		MDS accuracy from January			
		assessment further indicated		current. Any inaccuracies we			
	that the resident was			and further education was pro-			
	self-understood some			June 1, 2023.			
	understand others so			2c. On May 24, 2023 the Re	gional		
				Clinical Reimbursement Spec	cialist		
		nterviewed on 5/17/23 at		completed education on codi			
	-	ted that Resident #9 was		Resident Assessment Instrun			
		answer questions by		Manual for the two minimum			
		head. She stated that the		Data Set Nurses and the Soc			
		ctor was responsible for		3. Address what measures w			
		patterns and mood sections		place or systemic changes m			
	Director to try to inter	expected the Social Services		ensure that the deficient prac	uce will not		
				recur.			

Facility ID: 923526

If continuation sheet Page 2 of 29

	S FOR MEDICARE &		0.00			8-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345392	B. WING		05/18/20	23
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	, CODE	
WADESBO	ORO HEALTH & REHAB	CENTER		2051 COUNTRY CLUB ROAD WADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COME D THE APPROPRIATE D	(X5) PLETIO DATE
F 641	Continued From page	2	F 64	1		
	The Social Services I 5/17/23 at 10:11 AM. responsible for comp mood sections on the stated that the reside not try to interview the that she was new to I and she was still lear The Director of Nursii on 5/18/23 at 10:18 A expected the MDS as 3. Resident #55 was 9/7/22 with diagnoses weakness and chroni The quarterly Minimu assessment dated 2/2 #55 had clear speech self-understood and u Cognitive Patterns in Mental Status (BIMS) were not marked as a On 5/17/23 at 1:30 Pl with the MDS Nurse a Social Worker had co mood sections on Re assessment dated 2/2 state why the section correctly but an interv should have been attern	Director was interviewed on She reported that she was leting cognitive patterns and MDS assessments. She int was nonverbal, so she did e resident. She indicated MDS, started 2 months ago, ning. ang (DON) was interviewed M. The DON stated she assessments to be accurate. admitted to the facility on a that included muscle c kidney disease. m Data Set (MDS) 21/23 indicated Resident a and was able to make understood others. The cluding the Brief Interview for b, and the Mood sections assessed. M, an interview occurred #2, who indicated the former appleted the cognition and sident #55's quarterly MDS 21/23. She was unable to s were not completed view with Resident #55 empted for both sections.		<ul> <li>Reimbursement Specialis education on coding per Assessment Instrument ( the Minimum Data Set Nu Social Worker.</li> <li>3b. On May 24, 2023 the Reimbursement Specialis copy of the RAI Manual ff Minimum Data Set Nurse Worker.</li> <li>3c. The Minimum Data S conduct an audit of all MI correct discharge coding January 2024.</li> <li>4.Indicate how the facility its performance to make solutions are sustained.</li> <li>4a. Minimum Data Set Nurse #2 on their Minimum Data S an assessment audit tool weeks, then monthly x 12 of the audit will brought to Assurance Performance (QAPI)meeting by the Mii Nurse for review monthly any discrepancies are no action will be implemente administrator.</li> </ul>	the Resident RAI) Manual for urses and the Regional Clinical st provided a or the two as and the Social et nurses will DS records for July 2023 and r plans to monitor sure that urse #1 will audit and vice versa et accuracy on weekly x 12 2 months. Results o the Quality Improvement nimum Data Set x 12 months. If ted, further	
	5/18/23 at 10:16 AM	ng was interviewed on and stated it was her idents to be assessed				

If continuation sheet Page 3 of 29

	S FOR MEDICARE	MEDICAID SERVICES				IO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		TE SURVEY MPLETED
		345392	B. WING		0	5/18/2023
AME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	)E	
	ORO HEALTH & REHA	R CENTED	:	2051 COUNTRY CLUB ROAD		
	NO HEALIN & REHA	BOENTER	,	WADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETIC DATE
F 641	Continued From pa		F 641	1		
	diagnoses which in	s admitted on 12/08/22 with cluded type 2 diabetes, hronic obstructive pulmonary bation.				
	(MDS) assessment	harge Minimum Data Set dated 04/01/23 indicated the arged to acute hospital setting anticipated.				
	indicated Resident a during his stay and	mary, dated 03/31/23, #60 participated in therapy was discharged to another esident/family request.				
	Resident #60's elec	uction notes located in tronic medical record, dated the discharge destination was nome.				
	conducted with MD2 Resident #60's disc dated 04/01/23 and coded for acute hos anticipated. She rev discharge summary assessment was co MDS assessment s	PM an interview was S Nurse #1. She reviewed harge MDS assessment stated the discharge was spital setting with return not viewed the resident's and stated the MDS oded in error. She stated the hould have been coded to was discharged to another				
	(DON) 05/17/23 at 3 expectation the MD accurately.	with the Director of Nursing 3:15 PM she stated it was her S assessment be coded				
F 658 SS=D		Meet Professional Standards	F 658	3		6/9/23

Facility ID: 923526

If continuation sheet Page 4 of 29

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OME	3 NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		DATE SURVEY COMPLETED	
		345392	B. WING			05/18/2023	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE		
WADESBO	ORO HEALTH & REHAB	CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170				
(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) COMPLETIO DATE	
F 658	Continued From page	e 4	F 6	58			
	\$400.04(h)(0) Comm	abanaiya Cara Diana					
	§483.21(b)(3) Compr	d or arranged by the facility,					
		mprehensive care plan,					
	must-	· · · · · · · · · · · · · · · · · · ·					
	(i) Meet professional						
		is not met as evidenced					
	by:	ious and staff interviews the		1 Address how corrective	a action will be		
		iews and staff interviews, the cribe the correct medication		1. Address how corrective accomplished for those re			
		for 3 of 5 residents reviewed		have been affected by the			
		ications (Residents #13, #55		practice.			
	and #47).			1a. On May 18,2023 the I	Director of		
				Nursing(DON) reviewed F			
	The findings included	1:		(PCC)orders for residents The orders were corrected			
	1. Resident #13 was	originally admitted to the		2. Address how the facilit			
		h diagnoses which included		residents having the poter			
	gastro-esophageal re	eflux disease (GERD).		affected by the same defined and the same defined affected by the same defined and the same defined affected by the same defined aff			
	A quarterly Minimum	Data Set (MDS)		the PCC orders for all res			
		1/23 indicated Resident #13		facility and their correct a			
		and was independent after		route. No discrepancies w			
	setup with eating.			2b. Education for new nur			
				provided during orientatio			
		physician orders included		3. Address what measure			
		3 for Tums 500 milligrams ts enterally (by a feeding		place or systemic change ensure that the deficient p			
		GERD. All other medications		reoccur.	Mactice WIII HUL		
	were written to be pro			3a. On May 19, 2023 the	DON provided		
	'	-		education to all the nurses	•		
		AM, an interview occurred		order or confirming an orc			
		as working the medication		prescriber to enter the cor	rect route of		
		's hall and had administered		administration.	admianiana		
	medications earlier. T	ed all his medications by		3b. All admissions and rea orders will be double chec			
		ve a feeding tube. Nurse #1		accuracy 5x's/week during			
		edication Administration		clinical meeting.	y are morning		
		or Tums to be provided		4. Indicate how the facility			

Facility ID: 923526

If continuation sheet Page 5 of 29

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(¥2) MI II TI		NSTRUCTION		B NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· · · ·	COMPLETED
		345392	B. WING				05/18/2023
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
WADESBO	DRO HEALTH & REHAB	CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170				
(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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 658	Continued From page	e 5	F 65	58			
	enterally, which was medications were pro			s	nonitor its performance to make s olutions are sustained. .a. The DON or designee will run o		
	on 5/16/23 at 1:52 PM	is conducted with Nurse #2 A and confirmed Resident nedication by mouth and did be.		li n tl	sting report and check the 5 rights nedications ordered 5x's a week of ne morning meeting for 12 weeks nurse entering the order will receiv e-education immediately if any	s for the uring The	
	5/17/23 at 11:02 AM. confirmed the Tums of Unit Manager explain medication, dose and Medical System but r button and chose ent	d with the Unit Manager on She was the nurse that had order for Resident #13. The led she verified the I frequency in the Electronic nust have hit the wrong erally for the route rather		d ti n r	liscrepancies are identified. Resul ne audit will be brought to the QAI neeting monthly by the Administra eview. If any discrepancies are no urther action will be implemented administrator.	⊃I tor for oted,	
	(DON) was interview #13's physician order for the Tums was ent by mouth. The DON to the nurse chose ente The DON stated it was medication administra	AM, the Director of Nursing ed and reviewed Resident rs. She confirmed the route ered as enterally instead of felt it was an oversight that ral rather than by mouth. as her expectation for all ation routes to be entered der was received and					
		admitted to the facility on s that included dysphagia					
	#55 was able to unde self-understood. She with eating and receiv	Data Set (MDS) 21/23 indicated Resident erstand others and make required total assistance ved 51% or more of calories ) or more of fluids via a					

Facility ID: 923526

If continuation sheet Page 6 of 29

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/11/2023 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE	
		345392	B. WING			05/	18/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WADESBO	DRO HEALTH & REHAB	CENTER			2051 COUNTRY CLUB ROAD WADESBORO, NC 28170		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Continued From page	9 6	F	658	3		
		55's active care plan, last aled Resident #55 required					
	the following: " An order dated 1 milligrams (mg). Give three times a day for " An order dated 3 500 micrograms (mcg mouth one time a day syndrome. " Vistaril 25 mg. Gi every six hours as ne All other medications through the gastric fer On 5/16/23 at 11:23 A with Resident #55 wh supplemental tube fer and took all her medic She explained she ha	for Guillain-Barre we one capsule by mouth eded for pruritis (itching). were written to be provided eding tube.					
	Nurse #1 who was we for Resident #55's ha medications earlier. T Resident #55 did not mouth but received al tube. Nurse #1 was th order for Gabapentin order and confirmed i via the feeding tube a	take her medications by I of them by the feeding ne nurse who had taken the 300mg. She reviewed the t should have read to take					

Facility ID: 923526

If continuation sheet Page 7 of 29

CENTERS FOR MEDICARE & MEDICAID SERVICES     OMB NO. 09       STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION     (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A. BUILDING     (X3) DATE SUR COMPLETE	SURVEY
345392 B. WING 05/18/2	8/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
WADESBORO HEALTH & REHAB CENTER       2051 COUNTRY CLUB ROAD         WADESBORO, NC 28170	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)CO	(X5) COMPLETION DATE
F 658       Continued From page 7       F 658         1:52 PM and was familiar with Resident #55. She confirmed Resident #55 received all her medication via the feeding tube and not by mouth.       F 658         The Wound Nurse was interviewed on 5/16/23 at 2:00 PM. She was the nurse that transcribed the Cyanocobalamin 500 mcg order for Resident #55. The Wound Nurse explained she entered the medication, cose and frequency into the Electronic Medical System but failed to change the medication route to enterally (feeding tube).       On 5/18/23 at 10:16 AM, the Director of Nursing (IDON) was interviewed and reviewed Resident #55's physician orders. She confirmed the route for the Gabapentin, Cyanocobalamin and Vistarii were entered as by mouth instead of enterally as Resident #55 preferred to receive her medication, cover oblamin and Vistarii was an oversight and stated it was her expectation for all medication administration routes to be entered correctly when the order was received and verified.         Multiple phone calls were made to Nurse #3 who had taken the order for Vistarii 25mg and were unsuccessful.       3. Resident #47 was admitted to the facility on 9/15/2021 with diagnoses that included Guillain-Barre syndrome.         The resident's annual Minimum Data Set (MDS) dated 5/9/2023 indicated the resident was cognitively impaired and required extensive assistance with all activities of daily living including eating.	

Facility ID: 923526

If continuation sheet Page 8 of 29

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345392	B. WING			05/	18/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WADESB	ORO HEALTH & REHAB	CENTER			2051 COUNTRY CLUB ROAD WADESBORO, NC 28170		
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	The resident's compre- revised on 5/11/2023, nutritional risk related altered consistency d the resident had a pe gastrostomy (PEG) for Interventions included via PEG tube as order Resident # 47's media following physician or Crush each tablet and least 5ml of water or of Flush the tube with at other appropriate liqui medication administra Flush between medic 1/24/2023. Give Sertraline 1 table for major depressive Give Percocet 5-325, hours for chronic pair Give Gabapentin 600 times a day for neuro Give folic acid, 1 table for supplement. Give buspirone 15mg daily for anxiety. On 5/17/2023 at 10:1 conducted with Resid took all of her medica further stated she too On 5/17/2023 at 12:0 conducted with the Ut	ehensive care plan, last , contained a focus for to chewing difficulties and iet. The care plan indicated rcutaneous endoscopic or medications only. d administering medications red. cal record contained the ders: d empty each capsule into at other appropriate liquid. eleast 30 ml of water or id prior to and after each ation via tube separately. ations. The order was dated et by mouth every 12 hours disorder. 1 tablet by mouth every 12 n. mg , 1 tablet by mouth two	F	658			

Facility ID: 923526

If continuation sheet Page 9 of 29

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		345392	B. WING		05/18/2023
NAME OF PI	ROVIDER OR SUPPLIER	-	STF	REET ADDRESS, CITY, STATE, ZIP CODE	
WADESBO	ORO HEALTH & REHAB	CENTER		1 COUNTRY CLUB ROAD NDESBORO, NC 28170	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO
F 658	Continued From pag	e 9	F 658		
	with the resident. The difficulty with swallow PEG placement for r The resident had sin and was taking an al However, all of her r administered via the On 5/18/2023 at 10:0 conducted with the E She stated the reside and medications via the resident was get tube and not by mout transcribing the med expectation all medic correct route of administered	nedications were still PEG tube. 00 AM an interview was Director of Nursing (DON). ent takes nutrition by mouth PEG tube. She confirmed ting the medication via PEG th. She felt is was an error in ication order. It was her cation orders reflect the inistration.			
F 686 SS=D	CFR(s): 483.25(b)(1) §483.25(b) Skin Inter §483.25(b)(1) Presse Based on the compre- resident, the facility r (i) A resident receive professional standar pressure ulcers and ulcers unless the ind demonstrates that the (ii) A resident with pri- necessary treatment with professional standar promote healing, pre- new ulcers from deve	grity ure ulcers. ehensive assessment of a must ensure that- s care, consistent with ds of practice, to prevent does not develop pressure ividual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent ndards of practice, to event infection and prevent	F 686		6/9/23

Event ID: AHKN11

Facility ID: 923526

If continuation sheet Page 10 of 29

		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · · ·	ATE SURVEY OMPLETED
		345392	B. WING			05/18/2023
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI	P CODE	
WADESBO	ORO HEALTH & REHAB	CENTER				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 686	Continued From page	e 10	F 68	36		
	interviews, the facility alternating pressure is set according to the r residents reviewed for #24 and #40). The findings included 1. Resident #24 was 5/23/17. Her diagnos fracture of left hip, and A significant change (MDS) assessment of Resident #24 had set She was coded as had bony prominence and She had a pressure r A review of Resident reviewed 3/22/23, ind areas: - Potential for alterati prevention of recurre included an air mattro - Resident has impain Stage IV to the sacru- included an air mattro Resident #24's weigh (lbs.).	<ul> <li>y failed to ensure the reducing air mattress was resident's weight for 2 of 2 or pressure ulcers (Residents</li> <li>admitted to the facility on ses included dementia, and osteoarthritis.</li> <li>in status Minimum Data Set lated 3/14/23 indicated vere cognitive impairment. aving a pressure ulcer over a d one stage 4 pressure ulcer. reducing device to the bed.</li> <li>#24's active care plan, last cluded the following focus on in skin integrity and nt bruising. The interventions ess as ordered. red skin integrity related to um. The interventions</li> </ul>		<ul> <li>accomplished for those r have been affected by the practice.</li> <li>1a. On May 18, 2023 the Nursing (DON) met with Nurse concerning reside and their air mattress see Care Nurse states that u during the survey she im corrected the settings ar monitor them during the discrepancies identified a</li> <li>Address how the facil other residents having the affected by the same del 2a. On May 19, 2023 the nurse conducted an aud on an air mattress to ensistings were correct.</li> <li>2b. On May 26, 2023 the nurse, the DON and the and determined the two to utilize an air mattress promote wound healing a 2c. On May 19, 2023 the nurse labeled all air matt the required setting.</li> <li>Address what measur place or systemic chang ensure that the deficient reoccur.</li> <li>3a. Wound care nurse of audit monthly weights to</li> </ul>	e deficient e Director of the Wound Care ents #24 and #40 ttings. Wound pon notification mediately nd continued to survey. No after correction. lity will identify he potential to be ficient practice. e wound care it of all residents sure that the e wound care Administrator met different reasons for the resident to and for comfort. e Wound Care tress pumps with res will be put into es made to practice will not or designee to	
	11/21/22 to 5/16/23 r provided to a sacral p	evealed wound care was pressure ulcer.		mattress settings are con accordingly. 3b. Wound Care Nurse of	-	
		May 2023 physician orders an air mattress to the bed.		audit pumps 5x's a week ensure the pump's are la and the pump is on the c	abeled correctly	

Facility ID: 923526

If continuation sheet Page 11 of 29

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		NO. 0938-039 DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		C	OMPLETED
		345392	B. WING			05/18/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
WADESB	ORO HEALTH & REHAB	CENTER				
(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)	I SHOULD BE	(X5) COMPLETIO DATE
F 686	10	e 11 AM, an observation was	F 68	6 She will correct any discrepar	ncies	
	alternating pressure was set at 250 lbs. p machine had setting lbs., 200 lbs., 250 lbs lbs. and indicated to resident's weight per Resident #24 was of eyes closed on 5/16/ alternating pressure 250 lbs. On 5/16/23 at 11:15 with the Wound Nurs maintenance placed mattresses on the re she was responsible monitoring the mattre normally used the lo settings could not be occurred of Residen mattress and confirm 250 lbs. She verified 129 lbs. and set the Wound Nurse was u mattress machine ha Resident #24's weig The Director of Nurs 5/18/23 at 10:16 AM alternating pressure	A pounds. A poserved lying in bed with her (23 at 11:03 AM. The reducing mattress was set at AM, an interview occurred be. She explained the alternating air sident's beds as ordered but for setting the machines and esses. She further stated she ck out button so the weight altered. An observation t #24's alternating air ned the weight setting was on Resident #24's weight was machine correctly. The nable to explain why the ad been set incorrectly for		<ul> <li>3c. Director of Nursing or descheck orders for settings in PC Care (Electronic Medical Recensure staff are checking settishift.</li> <li>3d. All Certified Nursing Assistant's(CNA), nurses, Howill be educated on the air masettings, labels on the pumps mattress settings on the Kard 19, 2023 thru June 9, 2023.</li> <li>4. Indicate how the facility plantits performance tomake sure solutions are sustained.</li> <li>4a. The Director of Nurse or of complete a Low Air Loss Mattr Tool on residents weekly x 12 monthly x 12. Results of the abrought to the Quality Assura Performance Improvement M Administrator for review. If ar discrepancies are noted, furth be implemented by the Administration for the set of the administration of the set of the administration for review.</li> </ul>	ignee to oint Click ord) to ings every spice staff attress and the air ex on May hs to monitor that designee will ress Audit c, then hudit will be nce eeting by the hy her action will	
	2. Resident #40 was	admitted on 6/21/2022 with				

Facility ID: 923526

If continuation sheet Page 12 of 29

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/11/2023 APPROVED ). 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE		
		345392	B. WING				05/	18/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, Z	IP CODE			
WADESB	DRO HEALTH & REHAB	CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BI		(X5) COMPLETION DATE	
F 686	The resident's signific Set (MDS) dated 4/17 was cognitively intact assistance with activit stage 3 pressure injur admit, and had press Resident #40's comprevised 4/26/2023 had integrity related to imp included use of press ordered. Resident #40's medic physician's order date to bed. The medical re dated 5/16/2023 for w clean sacral wound w calcium alginate with dressing three times w Wednesday, and Frid On 5/15/23 at 11:00 A made of Resident #40 alternating pressure r was set at 250 lbs. per machine had settings lbs., 200 lbs., 250 lbs lbs. and indicated to s resident's weight per On 5/16/2023 at 10:00 observed lying in bed alternating pressure r 250 lbs.	<ul> <li>ant change Minimum Data 7/2023 indicated the resident , required extensive ties of daily living, had a y that was not present on ure reducing devices in bed.</li> <li>rehensive care plan was last d a focus for impaired skin baired mobility. Interventions ure relieving devices as</li> <li>al record included a ed 4/28/2023 for air mattress ecord also included an order yound care. The order read; ith wound cleaner, apply silver and cover with dry weekly on Monday, ay.</li> <li>AM, an observation was 0 lying in bed. The educing mattress machine er weight setting. The of 50 lbs., 100 lbs., 150 ., 300 lbs., 350 lbs., and 400 set according to the pounds.</li> <li>DAM Resident #40 was watching her ipad. The educing mattress was set at</li> <li>AM, an interview was 'ound Nurse. She explained</li> </ul>	F	586					

If continuation sheet Page 13 of 29

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345392	B. WING			05/	18/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
WADESB	WADESBORO HEALTH & REHAB CENTER				2051 COUNTRY CLUB ROAD NADESBORO, NC 28170		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 686 F 756 SS=E	mattresses on the resiste was responsible for monitoring the mattree normally used the loc settings could not be confirmed Resident # was on 250 lbs. She weight was 132 lbs. p set the machine corree was unable to explain had been set incorree weight. The Director of Nursin 5/18/23 at 10:16 AM a alternating pressure r to be set according to indicated on the mach Drug Regimen Review CFR(s): 483.45(c)(1)( §483.45(c) Drug Regi §483.45(c)(1) The drum must be reviewed at I licensed pharmacist. §483.45(c)(2) This rev of the resident's medi §483.45(c)(4) The pha- irregularities to the att facility's medical direct and these reports mu (i) Irregularities included drug that meets the c (d) of this section for a (ii) Any irregularities r	A sident's beds as ordered but for setting the machines and sses. She further stated she k out button so the weight altered. The Wound Nurse 40's alternating air mattress verified Resident #40's er her medical record and ectly. The Wound Nurse why the mattress machine ettly for Resident #40's and stated she expected the educing mattress machine the resident's weight as nine. w, Report Irregular, Act On 2)(4)(5) amen Review. Ig regimen of each resident east once a month by a view must include a review cal chart. armacist must report any tending physician and the etor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph		756			6/9/23

If continuation sheet Page 14 of 29

		MEDICAID SERVICES				<u>IO. 0938-03</u>	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION		TE SURVEY MPLETED	
		345392	B. WING		05/18/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
WADESBO	ORO HEALTH & REHAB	CENTER		2051 COUNTRY CLUB ROAD WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID CH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX SULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 756	Continued From page	e 14	F 75	56			
	separate, written repo						
		nd the facility's medical					
		of nursing and lists, at a					
		nt's name, the relevant drug,					
		e pharmacist identified.					
		sician must document in the					
		cord that the identified reviewed and what, if any,					
	- ·	n to address it. If there is to					
		nedication, the attending					
	-	ument his or her rationale in					
	the resident's medica	l record.					
	§483.45(c)(5) The fac	cility must develop and					
		procedures for the monthly					
		that include, but are not					
		s for the different steps in					
		s the pharmacist must take					
		ifies an irregularity that n to protect the resident.					
		is not met as evidenced					
	by:						
	Based on record rev	iews and interviews with		1. Address how corrective ac	tion will be		
		sultant and facility's Nurse		accomplished for those reside			
	Practitioner, the facili			have affected by the deficient			
	recommendations ma Consultant for 1 of 5			1a. On May 22, 2023 the Unit discussed a Consultation Rep			
		residents whose riewed (Resident #18).		concerning Resident #18 with			
		$\pi$		Nurse Practitioner (FNP).An c			
	The findings included	:		received to discontinue her ar			
	-			2. Address how the facility wil	lidentify		
		ost recently admitted to the		other residents have the poter			
		ith diagnoses which included		affected by the same deficit p			
	peripheral vascular d hypertension.	isease, heart disease, and		2a. On May 22, 2023 the Dire			
				Nursing (DON) and the Unit M audited 100% of the past 3 m			
	A review of the active	physician's order revealed		Pharmacy Consultation Report			
	an order dated 11/20			3. Address what measures wi			
		lligrams (mg) one tablet by		place or systemic changes ma			

Facility ID: 923526

If continuation sheet Page 15 of 29

		MEDICAID SERVICES		LE CONSTRUCTION		<u>NO. 0938-039</u> TE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	, <i>,</i>		· · ·	MPLETED		
		345392	B. WING		05/18/2023			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD				
WADESB	ORO HEALTH & REHAB	CENTER		2051 COUNTRY CLUB ROAD WADESBORO, NC 28170				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 756	Continued From page	e 15	F 75	6				
	mouth two times a da unspecified artificial h physician's orders ind Clopidogrel (an antica by mouth one time a thrombosis. A Pharmacy Consulta indicated Resident #7 twice a day and Clop The report indicated a continued use of both discontinued use of 0 deep vein thrombosis Practitioner responde the box that indicated recommendations(s) written." Review of the March Administration Recor #18 was administered 3/24/23 through 3/31, #18's April 2023 and Administration Recor received both Apixab day. Resident #18's quarte (MDS) assessment d was cognitively intact anticoagulant medicat	ay related to presence of hip joint. Another active dicated an order dated bagulant) 75 mg one tablet day for history for deep vein ation report dated 03/22/23 18 received Apixaban 2.5 mg idogrel 75 mg every day. a reevaluation of the n agents and to consider Clopidogrel for history of s. The facility's Nurse ed on 03/24/23 and checked I "I accept the above, please implement as 2023 Medication d (MAR) revealed Resident d Apixaban and Clopidogrel /23. A review of Resident May 2023 Medication d (MAR) revealed she an and Clopidogrel every erly Minimum Data Set ated 05/21/23 indicated she s, and she received tion 7 of 7 days.		<ul> <li>ensure that the deficient pract reoccur.</li> <li>3a. On May 23, 2023 the Pha Consultant met with the Unit M provided education on how to Pharmacy Consultation Report completion once the Providers addressed them.</li> <li>3b. The Administrator educate Director of Nursing (DON) on 2023 that going forward all Ph Consultation Reports, after be by the Provider, will be review Management RNs.</li> <li>4. Indicate how the facility pla monitor its performance to ma solutions are sustained.</li> <li>4a. 100% of the monthly Phar Consultation reports will be do reviewed by RN's to assure th recommendations were addres ordered by the Provider. Discridentified will be corrected imr 4b. Results of the Pharmacy O Report will be brought to the O Assurance Performance Impromeeting by the Administrator on Nursingfor review monthly x 1 any discrepancies are noted f will be implemented by the Administrator</li> </ul>	rmacy Manager and track ts s have ad the May 23, tarmacy ting signed ed by two ns to tke sure that macy puble at ssed as epancies nediately. Consultation Quality povement or Director of 2 months. If urther action			

Facility ID: 923526

If continuation sheet Page 16 of 29

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/11/2023 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE	
		345392	B. WING				05/	18/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP	CODE		
WADESBO	ORO HEALTH & REHAB	CENTED		2	051 COUNTRY CLUB ROAD			
WADESD	ORO HEALTH & REHAD	CENTER		V	VADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B		(X5) COMPLETION DATE
TAG F 756	Continued From page response to her recor would speak with the they have addressed The Unit Manager wa 3:20 PM. She stated p were faxed or emailed Consultant. She state the Medical Director of regarding the Pharma recommendations. Sh process the order for because she thought to continue both the A A phone interview wa Practitioner on 05/17/ she agreed with the p made in March to disc Clopidogrel and she e through. The Director of Nursir on 05/17/23 at 9:59 A Manager received the recommendations and Nurse Practitioner and Nurse Practitioner and Nurse Practitioner had medications in the res record. She stated the	e 16 nmendation. She stated she facility's staff to determine if the recommendations. s interviewed on 05/17/23 at oharmacy recommendations d to her by the Pharmacy d she would follow up with or Nurse Practitioner acy Consultant's		756				
	up in the electronic m Practitioner put the or nurse would have to a order is flagged for ac resident's electronic n the discontinuation of by the Nurse Practitio	edical record if the Nurse der in, and the resident's acknowledge it since the knowledgement in the nedical record. She stated Clopidogrel was not put in						

Facility ID: 923526

If continuation sheet Page 17 of 29

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY			
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED			
		345392	B. WING		05/18/2023			
NAME OF PI	ROVIDER OR SUPPLIER		STR					
WADESBO	DRO HEALTH & REHAB	CENTER		2051 COUNTRY CLUB ROAD WADESBORO, NC 28170				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLET			
F 756	1 0		F 756					
		ompleted if the Nurse						
F 758	-	vith the recommendation. vchotropic Meds/PRN Use	F 758		6/9/23			
SS=D	CFR(s): 483.45(c)(3)	•	1 7 30		0/0/20			
	§483.45(e) Psychotro §483.45(c)(3) A psyc	ppic Drugs. hotropic drug is any drug that						
		s associated with mental						
		vior. These drugs include,						
		drugs in the following						
	categories: (i) Anti-psychotic;							
	(ii) Anti-depressant;							
	(iii) Anti-anxiety; and (iv) Hypnotic							
	Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used							
	psychotropic drugs are not given these drugs							
		n is necessary to treat a						
	in the clinical record;	diagnosed and documented						
	drugs receive gradua behavioral interventio	ents who use psychotropic I dose reductions, and ons, unless clinically n effort to discontinue these						
	drugs;							
		ursuant to a PRN order						
		n is necessary to treat a ondition that is documented and						

Facility ID: 923526

If continuation sheet Page 18 of 29

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/11/20 FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345392	B. WING		05/18/2023
NAME OF PI	ROVIDER OR SUPPLIER	•	- I	STREET ADDRESS, CITY, STATE, ZIP CODE	•
		CENTER		2051 COUNTRY CLUB ROAD	
WADESD	DRO HEALTH & REHAB	CENTER		WADESBORO, NC 28170	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIV		
F 758	are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the PI beyond 14 days, he of rationale in the reside indicate the duration §483.45(e)(5) PRN of drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of This REQUIREMENT by: Based on record rev facility failed to limit the psychotropic medicate brain activities assoce and behavior) ordere needed (PRN) basis medications were rev #28). Findings included: 1. Resident #31 was 10/13/22 with multiple anxiety disorder. Resident #31 had a p 3/31/23 for Lorazepa milligrams (mgs) - 1 the prescribing and the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of	s. Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order. orders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. Γ is not met as evidenced	F 75	<ol> <li>Address corrective action will be accomplished for those residents for have been affected by the deficient practice.</li> <li>On May 19, 2023 the Unit Manag clarified Resident #28 and #31 for psychotropic meds with a stop date.</li> <li>On May 19, 2023 the DON educ the Hospice Nurse on residents #28 #31 to clarify the stop dates for as ne (PRN) psychotropic meds requirement and/or reassessment to be provided 1c. On May 19, 2023 the Hospice Nur- created a PRN medication order for the resident name, medication, and a date.</li> <li>Address how the facility will idention other residents having the potential for affected by the same deficient praction 2a. On May 19, 2023 the Unit Manag- conducted an audit of 100% residention</li> </ol>	ger ated and eeded ent urse m with stop fy to be ce. ger t in
		ge in status Minimum Data ent dated 4/3/23 indicated d moderate cognitive		the facility receiving prn psychotropic medications. One resident was found be affected. The Unit Manager cont	c d to

Facility ID: 923526

If continuation sheet Page 19 of 29

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED		
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	G		IPLETED		
		345392	B. WING			5/18/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE			
WADESB	ORO HEALTH & REHAB	CENTER		2051 COUNTRY CLUB ROAD WADESBORO, NC 28170				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE		
F 758	Continued From page	e 19	F 75	58				
	medication for 6 days period. Resident #31 had a p 4/11/23 for a Lorazep 6 hours PRN for anxis stop date. The April 2023 Medic Records (MARs) revereceived Lorazepam on 4/19/23 at 1:31 AM The May 2023 MARs had received Lorazep 5/5/23 at 8:01 PM, 5// 2:11 PM, 5/10/12 at 1 PM, 5/12/23 at 12:55 5/14/23 at 8:36 AM, 5 PM and on 5/17/23 at Nurse #4 was interviet The nurse reported th order from the hospic mgs by mouth every she transcribed it into stated that she was a psychotropic medicat	ealed that Resident #31 had on 4/14/23 at 8:53 PM and A. revealed that Resident #31 oam on 5/3/23 at 7:54 AM, 6/23 at 8:12 AM, 5/8/23 at 1:54 PM, 5/11/23 at 8:06 PM, 5/13/23 at 7:42 AM, 5/15/23 at 7:10 AM and 7:56		the Hospice Nurse and was received immediate 3.Address what measur place or systemic change ensure that the deficien recur. 3a.On May 19, 2023 the education to 100% of the the required regulation of 4. Indicate how the facil monitor its performance solutions are sustained. 4a. The DON or designe Point Click Care dashbod daily morning meeting fa all PRN psychotropic m week for 12 weeks. 4b. The DON or designe psychotropic medication weeks then monthly for Results of the audit will QAPI meeting for review months. If any discrepa will be corrected immed nurse transcribing the o reeducated.	ely. res will be put into ges made to t practice will not e DON provided he nursing staff on for a stop date. lity plans to e to make sure that during the or a stop date on edications 5x ee will audit PRN hs weekly for 12 12 months. be brought to the w monthly for 12 ancies are noted it liately and the			
	on 5/18/23 at 10:18 A would have expected psychotropic medicat	ng (DON) was interviewed M. The DON stated she orders for PRN ions including Lorazepam to n for hospice residents.						

If continuation sheet Page 20 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES         CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345392         NAME OF PROVIDER OR SUPPLIER		· /	ING _	E CONSTRUCTION	PRINTED: 07/11/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 05/18/2023		
	ROVIDER OR SUPPLIER	CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD		
IIAD LOD		SERVER		V	WADESBORO, NC 28170		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	<ol> <li>Resident #28 was a 4/27/23 with multiple disorder.</li> <li>Resident #28 had a p 4/27/23 for a Lorazep 6 hours PRN for anxie a stop date.</li> <li>The admission MDS a indicated that Residen decision-making prob an antianxiety medica assessment period.</li> <li>The April 2023 Medic Records (MARs) rever received Lorazepand on 4/29/23 at 8:39 AM</li> <li>The May 2023 MARs had received Lorazep and 8:11 PM, 5/4/23 at 5/6/23 at 7:47 AM, 5/8 PM, 5/9/23 at 8:32 AM 8:45 AM, 5/11/23 at 1 5/13/23 at 7:43 AM, 5 at 7:09 AM and 7:59 F AM.</li> <li>The Unit Manager wa 10:55 AM. The Unit M Resident #28 was add order of Lorazepan 0 hours PRN on 4/27/23 the computer. The Ur was aware that an ord</li> </ol>	admitted to the facility on diagnoses including anxiety hysician's order dated am 0.5 mgs by mouth every ety. The order did not have assessment dated 5/4/23 nt #28 had memory and dems and she had received ation for 4 days during the ation Administration ealed that Resident #28 had on 4/28/23 at 7:25 AM and A and 8:23 PM. revealed that Resident #28 bam on 5/3/23 at 2:12 PM at 3:10 AM and 8:27 PM, B/23 at 8:47 AM and 8:39 M and 9:11 PM, 5/10/23 at 2:30 AM and 5:01 PM, 5/14/23 at 8:26 AM, 5/15/23 PM, and on 5/16/23 at 7:28 as interviewed on 5/17/23 at Manager reported that mitted to the facility with an 0.5 mgs by mouth every 6 3 and she transcribed it into nit Manager stated that she der for PRN psychotropic a stop date of 14 days, but	F	758	3		

If continuation sheet Page 21 of 29

					OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345392	B. WING		05/18/2023	
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
VADESBO	DRO HEALTH & REHAB	CENTER		2051 COUNTRY CLUB ROAD NADESBORO, NC 28170		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE	
F 758	Continued From page	e 21	F 758			
F 760 SS=E	on 5/18/23 at 10:18 A would have expected psychotropic medicat have a stop date eve Residents are Free o	ng (DON) was interviewed M. The DON stated she orders for PRN ions including Lorazepam to n for hospice residents. f Significant Med Errors	F 760		6/9/23	
	medication errors. This REQUIREMENT by: Based on record rev Nurse Practitioner an facility failed to ensur was restarted after su resident (Resident #4 anticoagulant use. The findings included Resident #40 was ad diagnoses that includ heart rhythm), hypert pressure), and history (stroke). The resident's signific Set (MDS) dated 4/17 was cognitively intact assistance with activi indwelling urinary cat anticoagulation thera	<ul> <li>is not met as evidenced</li> <li>is not met as evidenced</li> <li>iews and interviews with the d the Medical Director, the e anticoagulation therapy urgical procedure for 1 of 1 to 100 reviewed for</li> <li>i: mitted on 6/21/2022 with ed atrial fibrillation (irregular ension (high blood y of a cerebral infarct</li> <li>cant change Minimum Data 7/2023 indicated the resident to the resident to the resident to the soft daily living, had an heter, and received</li> </ul>		<ol> <li>Address how corrective action will b accomplished for those residents found have been affected by the deficient practice.</li> <li>On May 15,2023 the Director of Nursing (DON) contacted the (FNP) Family Nurse Practitioner to discuss th anti-coagulant medication orders for Resident #40. The (FNP) Family Nurse Practitioner ordered aspirin to be resta on May 15, 2023 and restart Eliquis on May 16, 2023.</li> <li>On May 15, 2023 the Director of Nursing (DON)completed a medication error report.</li> <li>Address how the facility will identify other residents having the potential to affected by the same deficient practice 2a. On May 16,2023 the Director of Nursing (DON) conducted an audit of consult sheets for 100% of the resident that have been out of the facility for an appointment or out patient procedure.</li> </ol>	d to e rted be ·	

Facility ID: 923526

If continuation sheet Page 22 of 29

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345392	` '		(X3) DATE SURVEY COMPLETED		
	345392		G			
	NAME OF PROVIDER OR SUPPLIER			05/18/2023		
O HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE			
WADESBORO HEALTH & REHAB CENTER			2051 COUNTRY CLUB ROAD WADESBORO, NC 28170			
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIC		
omplications related iterventions included redered and calling M ffects. esident #40's medic ummary from the sur /28/2023. The summ as evaluated and de uprapubic catheter p lan included disconti pixaban, three days he Medication Admin pril 2023 revealed th as discontinued on 4 esident #40's discha urgical clinic dated 4 esident had a suprap ischarge summary in esume taking the ant londay (3 days post urse Practitioner (NI 40 on her return to th as no indication she be restarted 72 hou esident #40's MARs evealed the anticoag estarted. pharmacy review w	to anticoagulation therapy. d giving medication as ledical Director with any side al record included a visit rgical clinic dated hary indicated the resident eemed a candidate for blacement. The discharge inuing her anticoagulant, prior to surgical procedure. Inistration Record (MAR) for he anticoagulant Apixaban 4/17/2023. arge summary from the /21/2023 indicated the bubic catheter placed. The ndicated the resident should ticoagulant Apixaban on procedure). P) #1 assessed Resident he facility 4/21/2023. There e ordered the anticoagulant urs post procedure. for April and May 2023 julant Apixaban was never as conducted 4/18/2023	F 76	<ul> <li>3. Address what measures will I place or systemic changes mad ensure that the deficient practice recur.</li> <li>3a. On May 19, 2023 the Directe Nursing (DON) provided educat 100% of the nurses concerning orders for residents returning from appointment or out patient proced. The Nurses are to notify the promany new recommendations on the sheet.</li> <li>4. Indicate how the facility plans monitor its performance to make solutions are sustained.</li> <li>4a. The Administrator or designed complete an out of facility/out paprocedure audit tool on the reside weekly x 12, then monthly x12. The suits of the audit will brought the Quality Assurance Performance Improvement meeting by the adfor review. If any discrepancies further action will be implemented administrator.</li> </ul>	e to e will not or of ion to follow up om an edure. vider of he consult to e sure that ee will atient dents The o the ministrator are noted		
	ontinued From page omplications related terventions included rdered and calling M fects. esident #40's medic ummary from the su '28/2023. The summ as evaluated and de uprapubic catheter p an included disconti- pixaban, three days he Medication Admin pril 2023 revealed th as discontinued on a esident #40's discha- urgical clinic dated 4 esident had a suprap- scharge summary in soume taking the an- ionday (3 days post urse Practitioner (NI 40 on her return to th as no indication she be restarted 72 hou esident #40s MARs evealed the anticoag estarted. pharmacy review w ith no irregularities r lay 2023 had not yet n 5/17/2023 at 10:1	esident #40's medical record included a visit ummary from the surgical clinic dated (28/2023. The summary indicated the resident as evaluated and deemed a candidate for uprapubic catheter placement. The discharge an included discontinuing her anticoagulant, pixaban, three days prior to surgical procedure. The Medication Administration Record (MAR) for pril 2023 revealed the anticoagulant Apixaban as discontinued on 4/17/2023. esident #40's discharge summary from the urgical clinic dated 4/21/2023 indicated the sident had a suprapubic catheter placed. The scharge summary indicated the resident should esume taking the anticoagulant Apixaban on londay (3 days post procedure). urse Practitioner (NP) #1 assessed Resident 40 on her return to the facility 4/21/2023. There as no indication she ordered the anticoagulant o be restarted 72 hours post procedure.	ontinued From page 22       F 70         proplications related to anticoagulation therapy.       terventions included giving medication as         rdered and calling Medical Director with any side       fects.         esident #40's medical record included a visit       ummary from the surgical clinic dated         28/2023. The summary indicated the resident       as evaluated and deemed a candidate for         uprapubic catheter placement. The discharge       an included discontinuing her anticoagulant,         pixaban, three days prior to surgical procedure.       he Medication Administration Record (MAR) for         pril 2023 revealed the anticoagulant Apixaban       as discontinued on 4/17/2023.         esident #40's discharge summary from the       urgical clinic dated 4/21/2023 indicated the         usident had a suprapubic catheter placed. The       scharge summary indicated the resident should         usume taking the anticoagulant Apixaban on       nonday (3 days post procedure).         urse Practitioner (NP) #1 assessed Resident       40 on her return to the facility 4/21/2023. There         as no indication she ordered the anticoagulant       be restarted 72 hours post procedure.         esident #40s MARs for April and May 2023       evaled the anticoagulant Apixaban was never         urse Practitioner (NP) was conducted 4/18/2023       evalued the anticoagulant Apixaban was never         evaled the anticoagulant Apixaban was never       evaled t	DEFICIENCY)       ontinued From page 22       omplications related to anticoagulation therapy.       terventions included giving medication as       dered and calling Medical Director with any side       fects.       esident #40's medical record included a visit       ammary from the surgical clinic dated       22/2023. The summary indicated the resident       as evaluated and deemed a candidate for       apropubic catheter placement. The discharge       an included discontinuing her anticoagulant,       pixaban, three days prior to surgical procedure.       he Medication Administration Record (MAR) for       pri esident #40's discharge summary from the       argical clinic dated 4/21/2023.       solutions are sustained.       4a. The Administrator or design       complication she ordered the resident should       sume taking the anticoagulant Apixaban on       onday (3 days post procedure).       urse Practitioner (NP) #1 assessed Resident       40 on her return to the facility 4/21/2023. There       as no indication she ordered the anticoagulant       be restarted 72 hours post procedure.       esident #40s MARs for April and May 2023       wealed the anticoagulant Apixaban was never       urstrated.       pharmacy review was conducted 4/18/2023       the no irregularities noted. A pharmacy review for       ay 2023 had not yet been completed.		

If continuation sheet Page 23 of 29

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/11/2023 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	
		345392	B. WING _			05/	18/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WADESBO	DRO HEALTH & REHAB	CENTER			051 COUNTRY CLUB ROAD VADESBORO, NC 28170		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760 F 867 SS=E	did not recall why Res anticoagulant, he wou at her medical record not aware the anticoa On 5/17/2023 at 3:03 conducted with the Ne the anticoagulant was placement of the supr not sure why the antic The resident returned Friday and the discha been available to her have expected the an restarted 3 days post clinic's discharge sum she had restarted the 5/17/2023. QAPI/QAA Improvem CFR(s): 483.75(c)(d)( §483.75(c) Program fr monitoring. A facility must establis policies and procedur collections systems, a adverse event monito procedures must inclu following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representativ information will be use	sident #40 was on an IId have to go back and look . He further stated he was gulant was not restarted. PM a phone interview was urse Practitioner. She stated a stopped due to the rapubic catheter. She was coagulant was not restarted. from the clinic late on rge summary may not have at that time. She would ticoagulant to have been procedure per the surgical mary. She further stated resident on anticoagulant ent Activities e)(g)(2)(i)(ii) eedback, data systems and sh and implement written es for feedback, data and monitoring, including ring. The policies and ude, at a minimum, the maintenance of effective d use of feedback and input other staff, residents, and res, including how such ed to identify problems that ume, or problem-prone, and		367			6/9/23

Event ID: AHKN11

Facility ID: 923526

If continuation sheet Page 24 of 29

	-	ID HUMAN SERVICES				FORM	): 07/11/2023 1 APPROVED
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345392	B. WING		_	05/	18/2023
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
WADESBORO HEALTH & REHAB CENTER				2051 COUNTRY CLUB RO NADESBORO, NC 281			
(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 867	§483.75(c)(2) Facility systems to identify, co information from all de not limited to the facilit §483.70(e) and include will be used to develo indicators. §483.75(c)(3) Facility and evaluation of perfinct including the methodo development, monitor §483.75(c)(4) Facility including the methodos systematically identify analyze and use data adverse events in the facility will use the dat prevent adverse events §483.75(d) Program s systemic action. §483.75(d)(1) The fac aimed at performance implementing those a and track performance implement policies ad (i) How they will use a determine underlying impacting larger syste (ii) How they will deve will be designed to eff	maintenance of effective ollect, and use data and epartments, including but ity assessment required at ling how such information op and monitor performance development, monitoring, formance indicators, ology and frequency for such ring, and evaluation. adverse event monitoring, s by which the facility will $\gamma$ , report, track, investigate, and information relating to facility, including how the ta to develop activities to its. systematic analysis and cility must take actions e improvement and, after ctions, measure its success, e to ensure that alized and sustained. cility will develop and ldressing: a systematic approach to causes of problems	F 867				

If continuation sheet Page 25 of 29

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/11/2023 APPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345392	B. WING			05/	18/2023
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
WADESBORO HEALTH & REHAB CENTER					151 COUNTRY CLUB ROAD ADESBORO, NC 28170		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 867	SPRO HEALTH & REHAB CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 25 safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.         §483.75(e) Program activities.         §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.         §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.         §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects. The number and frequency of improvement projects conducted by the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).         Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.         §483.75(g) Quality assessment and assurance.		F 8	67			

If continuation sheet Page 26 of 29

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/11/202 FORM APPROVE OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345392			(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED			
		B. WING		05/18/2023			
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
			2051 COUNTRY CLUB ROAD				
WADESBO	JRU HEALTH & REHAB	CENTER		WADESBORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	N SHOULD BE COMPLETIO E APPROPRIATE DATE		
F 867	<ul> <li>EFIX REGULATORY OR LSC IDENTIFYING INFORMATION)</li> <li>F 867</li> <li>Continued From page 26 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:</li> <li>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:</li> <li>Based on record reviews, observations, Nurse Practitioner, Pharmacy Consultant, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification survey on 11/18/21. This was for four deficiencies that were cited in the areas of Accuracy of Assessments, Reporting and Acting on Reports of Drug Irregularities, Drug Regimen is Free From Unnecessary Psychotropic Meds and Significant Med Errors. The duplicate citations during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program.</li> </ul>		WADESBORO, NC 28170           ID PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)           F 867         I. Address how the corrective action be accomplished for those residents found to have been affected by the deficient practice.           I. The Quality Assurance Process w re-evaluated by the Administrator an DON on 5/31/23 including monitoring F641,F658 F686, F758,F760, F756. Administrator and the DON (Director Nursing) reviewed the Federal Regu for tags.           2. Address how the facility will idention other residents having the potential affected by the same deficit practice 2a.On May 22, 2023 the Administrator		nts e was and the ring for 66. The tor of gulation ntify al to be ce. rator and s and		
	The findings included			QA audits for the past 6 months to any needs for additional monitorin 3. Address how measures will be place or systemic changes made t	g. put into		
		ord review and staff interview,		ensure that the deficient practice v reoccur.			
	the facility failed to a	ccurately code the Minimum		3a. On May 25, 2023 The Adminis	strator		

Event ID: AHKN11

Facility ID: 923526

If continuation sheet Page 27 of 29

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345392 B. WING 05/18/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO HEALTH & REHAB CENTER WADESBORO, NC 28170 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 867 Continued From page 27 F 867 Data Set (MDS) assessments for 4 of 16 and the DON were re-educated by the sampled residents whose MDS were reviewed **Regional Vice President of Operations** (Residents #9, #31, #55 & #9). related to requirements of F867. 3b. On May 31,2023 the Administrator During the facility's recertification survey of re-educated the QAPI team related to 11/18/21, the facility failed to code the Minimum maintaining implemented procedures and Data Set (MDS) assessments accurately in the follow up monitoring of the interventions areas of smoking and disposition for 2 of 25 or procedures that are implemented in sampled residents reviewed. order to sustain compliance as required. 4. Indicate how the facility plans to In an interview with the Administrator on 05/18/23 monitor it performance to make sure that at 9:40 AM, she felt the repeat citation in MDS solutions are sustained. accuracy was felt to be related to human error. 4a. The Administrator or designee will complete a QAPI Audit Tool monthly x 12 F756- Based on record reviews and interviews to ensure systems and processes with staff, Pharmacy Consultant and facility's continue to be monitored and follow up Nurse Practitioner, the facility failed to act upon completed as required. Results of the recommendations made by the Pharmacy audit will be brought to the Quality Consultant for 1 of 5 residents whose Assurance Performance Improvement medications were reviewed (Resident #18). Meeting by the Administrator for review. If any discrepancies are noted, further During the facility's recertification survey of action will be implemented by the 11/18/21, the Pharmacy Consultant failed to Administrator. address the use of an as needed (PRN) psychotropic medication without a stop date for 1 of 6 residents reviewed for unnecessary medications. In an interview with the Administrator on 05/18/23 at 9:40 AM, she stated this error should have been addressed by the Pharmacist Consultant because she reviewed the orders. F758- Based on record review and staff interview, the facility failed to limit the timeframe for a psychotropic medication (any drug that affects the brain activities associated with mental processes and behavior) ordered to be given on an as needed (PRN) basis for 2 of 2 residents whose

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

If continuation sheet Page 28 of 29

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & MI					FORM	): 07/11/2023 APPROVED . 0938-0391
	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345392	B. WING		-	05/ <sup>,</sup>	18/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
WADESBORO HEALTH & REHAB CE	ENTER		2051 COUNTRY CLUB ROAD WADESBORO, NC 28170			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
<ul> <li>(PRN) psychotropic me in duration for 1 of 6 resunnecessary medication</li> <li>In an interview with the at 9:40 AM, she felt like</li> <li>F760- Based on record with the Nurse Practition</li> <li>Director, the facility faile anticoagulation therapy surgical procedure for 1 #40) reviewed for antico</li> <li>During the facility's recent 11/18/21 the facility faile were free of significant 1 reviewed for medication</li> </ul>	wed (Residents #31 & ertification survey of ed to ensure an as needed dication was time limited sidents reviewed for ns. Administrator on 05/18/23 e it was an oversight. reviews and interviews ner and the Medical ed to ensure was restarted after of 1 resident (Resident bagulant use. ertification survey of ed to ensure residents medication errors for 1 of on errors. Administrator on 05/18/23 this error should have Pharmacist Consultant	F 86		EFICIENCY)		

Facility ID: 923526

If continuation sheet Page 29 of 29