PRINTED: 08/29/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345066	B. WING			1	C 29/2023
	VIDER OR SUPPLIER	ITER		47	TREET ADDRESS, CITY, STATE, ZIP CODE 748 OLD SALISBURY ROAD EXINGTON, NC 27295	, 30.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
SS=F C Si	403.748(a), §416.54 441.184(a), §460.84 443.475(a), §484.10 485.542(a), §485.62 485.920(a), §486.36 494.62(a). he [facility] must comederal, State and locareparedness requires evelop establish and mergency preparedness programmited to, the following a) Emergency Plan. In a maintain an emernat must be [reviewed very 2 years. The plollowing: [For hospitals at §48 485.625(a):] Emerge AH] must comply with tate, and local emergency preparedness and local emergency preparedness of this sell-hazards approach. [For LTC Facilities at lan. The LTC facility in emergency preparedness and updates eviewed, and updates eviewed.	(a), §482.15(a), §483.73(a), 2(a), §485.68(a), 5(a), §485.727(a), 5(a), §491.12(a), apply with all applicable real emergency ments. The [facility] must maintain a comprehensive ress program that meets the rection. The emergency relation must include, but not be greater elements: The [facility] must develop gency preparedness plantal, and updated at least an must do all of the 2.15 and CAHs at recy Plan. The [hospital or thall applicable Federal, gency preparedness pospital or CAH] must a comprehensive ress program that meets the rection, utilizing an 1 §483.73(a):] Emergency must develop and maintain redness plan that must be		004	TITI E		8/2/23

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/19/2023

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 those decreases are pade exceptible to the facility. If deficiencies are extend on approved plan of correction is required to continued.

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.

. . .

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

Electronically Signed

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345066		B. WING _			06/29/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4748 OLD SALISBURY ROAD LEXINGTON, NC 27295	E	06/29/2023	
(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) COMPLETION DATE	
E 004	* [For ESRD Facilities Plan. The ESRD facil maintain an emergen must be [evaluated], years. . This REQUIREMENT by: Based on record rev facility failed to ensur Preparedness (EP) pupdated at least annu. The findings included The facility's EP plan include when the last the date initiated. Oth plan were present. An interview with the Operations was cond AM. She indicated the management Deceming the EP book had not	s at §494.62(a):] Emergency ity must develop and cy preparedness plan that and updated at least every 2 is not met as evidenced iew and staff interview, the e the Emergency lan was reviewed and ually.	E	Problem: F944 The facility failed to revi Emergency Preparedness Pla Corrective action for affected On 7-6-2023, the interdisciplir reviewed the facility Emergen Preparedness Plan and signe review How will the facility identify ot residents that have the potent affected and what corrective a done All residents have the ability t by facility failing to review the preparedness plan. What will you do to prevent the recurring or what systemic ch implement To prevent this from recurring Administrator was educated to Regional Director of Clinical S 7-14-2023, on the regulation of make updates to their Emerge Preparedness Plan yearly and interdisciplinary team sign off review.	resident nary team ncy ed off on the her like tial to be action will be o be effecte ir emergence his from ange will you the Services on to review are ency d to have th	e ed cy ou	

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		345066	B. WING	B. WING		C 06/29/2023	
	ROVIDER OR SUPPLIER			47	REET ADDRESS, CITY, STATE, ZIP CODE 48 OLD SALISBURY ROAD EXINGTON, NC 27295	06/	29/2023
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E 004	Continued From page	. 2	E	004	Any new administrator will receive this same education upon hire. How will you monitor and maintain ongoing compliance To monitor and maintain ongoing compliance beginning 8-2-2023. The administrator will include the need to review their emergency preparedness plan with the QAPI meeting. QAPI The results of the audits will be forward to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance.		
F 000	6/29/23. The following NC00201015, NC001 NC00201115 and NC complaint allegations	ey and complaint nducted 6/26/23 through g intakes were investigated: 97377,NC00200717, 00199940. None of the 20 resulted in a deficiency. I Incident NC00202870 by based on the	F	000	Date of compliance is 8-2-2023.		
F 641 SS=B	Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status.	ents	F	541			8/2/23

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345066 B.			C 06/29/2023		
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/20/2020		
DAVIDSOI	N HEALTH & REHAB CE	NTER		4748 OLD SALISBURY ROAD LEXINGTON, NC 27295			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 641	Continued From pag	e 3	F 64	11			
	Based on record rev and staff interviews, Minimum Data Set (N in the areas of dispos of motion (Resident a	riew, observation, Physician the facility failed to code the MDS) assessment accurately sition (Resident #94), range		Problem F641 Assessment Accuracy: Facility faile accurately code section A. discharg status, G functional limitations in ramotion and P use of restraints on the MDS.	ge nge of		
	The findings included: 1) Resident #94 was admitted to the facility on 4/6/23 with diagnoses that included coronary artery disease, polyosteoarthritis and diabetes type 2. He was discharged home on 5/6/23.			Corrective action for affected reside On 6-29-2023 a modification was submitted for resident #26 correcting coding for limitations in ROM section the MDS.	ng the		
	The Admission Minin assessment dated 4/ #94 was cognitively i discharged to the cordischarge planning when A nursing progress in Resident #94 was disvehicle with a family Review of the Discharged to the accompleted with MDS resident was marked	num Data Set (MDS) 12/23, indicated Resident ntact, expected to be mmunity and active vas occurring. ote dated 5/6/23 indicated scharged home in a private member. arge MDS assessment dated ident #94 was coded as ute care hospital.		On 6-28-2023 a modification was submitted for resident #79 correctin coding for restrains section P on the assessment. On 7-5-2023,a modification was submitted for resident #94 correctin coding for discharge location section the MDS assessment. How will the facility identify other like residents that have the potential to affected and what corrective action done. To identify other residents who have potential to be affected on 7/17/23 audit was completed reviewing MD assessments for the last 30 days for accurate coding of section A-discharge motion, and section P restraints. Ar issues Identified were corrected.	e MDS ag the on A on ae be will be e the an S or arge e of		
		admitted on 4/30/2021. Her cerebral infarction (stroke), e right hand.		What will you do to prevent this from recurring or what systemic change implement			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENITIFICATION NITIMBED:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	29/2023	
					748 OLD SALISBURY ROAD			
DAVIDSO	N HEALTH & REHAB CE	NTER			EXINGTON, NC 27295			
	I				T		I	
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F 641		e 4 ehensive care plan was last nd contained a focus for	F 6	641	To prevent this from recurring on 7/17/2 the Regional MDS Consultant educated the MDS coordinators on accurately			
	self-care deficit related to right sided hemiplegia and hemiparesis.				coding section A, G, and P on MDS assessments per the RAI manual.			
	dated 5/3/2023 indica	al Minimum Data Set (MDS) ated the resident was without of motion impairment.			All new MDS coordinators will receive to same education prior to completing MD assessments.			
	On 6/29/2023 at 11:40AM and interview was conducted with the MDS nurse. She stated the resident should have been coded to reflect impairment of one upper and one lower extremity. The MDS was coded in error. 3) Resident #79 was admitted to the facility on 2/28/23 with an initial admission date of 7/5/22. Resident #79's diagnosis included stroke, hemiplegia or hemiparesis, and generalized muscle weakness. Resident #79 was discharged to the hospital on 6/26/23. Review of Resident #79's medical record showed a Side Rail Evaluation Admit/Annual assessment dated 8/16/22. The assessment showed Resident #79 used the side rails for positioning, turning, and support. The assessment also showed Resident #79 requested to have side rails and the side rails allowed him to be more independent.				How will you monitor and maintain ongoing compliance To monitor and maintain ongoing compliance beginning 7- 24-2023, the MDS consultant or designee will au 5 MDS assessments per week X 12 weeks for accurate completion of section A,G, and P. QAPI The results of the audits will be forward to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance. Date of compliance is 8-2-2023.	on		
	may have bilateral be mobility and transfers hemiparesis. Review of the quarter assessment dated 3/3	n order dated 3/6/23 read edrails for safety with bed is for stroke with left or strok						

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			STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD LEXINGTON, NC 27295	06/23/2023	
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Continued From page	e 5	F 6	41		
on 6/23/23 showed a was at risk for injury/i bed rails. Resident #7 and side rails helped independence. Interva decline in mobility rails with the MDS Noreviewed Resident #7 indicated Resident #7 assist him with mobili a restraint. During the	focus area Resident #79 mmobility related to bilateral 79 had left-sided weakness aide in bed mobility and entions included monitor for eevaluate for continued use. ducted on 6/28/23 at 1:54 urse #2. The MDS Nurse #2 79's medical record and 79 used the bed rails to ty and the bed rails were not e interview, MDS Nurse #2				
P.M. with the Director the interview, the DO bed rails were used to while in bed and they further indicated the N inaccurately. Pharmacy Srvcs/Proc	of Nursing (DON). During N indicated Resident #79's assist him with his mobility were not a restraint. She MDS was marked cedures/Pharmacist/Records	F 7	55	8/2/23	
§483.45 Pharmacy S The facility must prov drugs and biologicals them under an agree §483.70(g). The facil personnel to administ permits, but only under a licensed nurse.	ervices ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed ter drugs if State law er the general supervision of				
	ROVIDER OR SUPPLIER N HEALTH & REHAB CE SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page Review of Resident # on 6/23/23 showed a was at risk for injury/i bed rails. Resident #7 and side rails helped independence. Intervate a decline in mobility reviewed Resident #7 indicated Resident #7 assist him with mobility a restraint. During the indicated the MDS remarked accurately. An interview was con P.M. with the Director the interview, the DO bed rails were used to while in bed and they further indicated the Minaccurately. Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b): §483.45 Pharmacy SThe facility must providings and biologicals them under an agree §483.70(g). The facil personnel to administ permits, but only under a licensed nurse.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 Review of Resident #79's care plan last updated on 6/23/23 showed a focus area Resident #79 was at risk for injury/immobility related to bilateral bed rails. Resident #79 had left-sided weakness and side rails helped aide in bed mobility and independence. Interventions included monitor for a decline in mobility reevaluate for continued use. An interview was conducted on 6/28/23 at 1:54 P.M. with the MDS Nurse #2. The MDS Nurse #2 reviewed Resident #79's medical record and indicated Resident #79's medical record and indicated Resident #79's medical record and indicated Resident #79's used the bed rails to assist him with mobility and the bed rails were not a restraint. During the interview, MDS Nurse #2 indicated the MDS restraint section was not marked accurately. An interview was conducted on 6/29/23 at 12:17 P.M. with the Director of Nursing (DON). During the interview, the DON indicated Resident #79's bed rails were used to assist him with his mobility while in bed and they were not a restraint. She further indicated the MDS was marked inaccurately. Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	ROVIDER OR SUPPLIER N HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 Review of Resident #79's care plan last updated on 6/23/23 showed a focus area Resident #79 was at risk for injury/immobility related to bilateral bed rails. Resident #79 had left-sided weakness and side rails helped aide in bed mobility and independence. Interventions included monitor for a decline in mobility reevaluate for continued use. An interview was conducted on 6/28/23 at 1:54 P.M. with the MDS Nurse #2. The MDS Nurse #2 reviewed Resident #79 wad the bed rails to assist him with mobility and indicated Resident #79 used the bed rails were not a restraint. During the interview, MDS Nurse #2 indicated the MDS restraint section was not marked accurately. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 4748 CLD SALISBURY ROD LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEPICIENCIES [EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYMS INFORMATION) Continued From page 5 Review of Resident #79's care plan last updated on 6/23/23 showed a focus area Resident #79 was at risk for injury/immobility related to bilateral bed rails. Resident #79 had left-sided weakness and side rails helped aide in bed mobility and independence, Interventions included monitor for a decline in mobility revaluate for continued use. An interview was conducted on 6/28/23 at 1:54 P.M. with the MDS Nurse #2. The MDS Nurse #2 reviewed Resident #79 used the bed rails to assist him with mobility and the bed rails were not a restraint. During the interview, MDS Nurse #2 indicated the MDS restraint section was not marked accurately. An interview was conducted on 6/29/23 at 12:17 P.M. with the Director of Nursing (DON). 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F 755	that assure the accur dispensing, and admibiologicals) to meet the \$483.45(b) Service Comust employ or obtain pharmacist who- \$483.45(b)(1) Provide aspects of the provision the facility. \$483.45(b)(2) Establication receipt and disposition sufficient detail to enarconciliation; and \$483.45(b)(3) Determined and performed and that an accompany is a service of the provision of th	ces (including procedures ate acquiring, receiving, inistering of all drugs and the needs of each resident. consultation. The facility in the services of a licensed es consultation on all fon of pharmacy services in shes a system of records of in of all controlled drugs in able an accurate	F 7	Problem F755 The facility failed provide neresident desired and what corrective action the facility How will the facility identify other light facility How action the facility identify other light facility How desired and what corrective action done To identify other residents who have	dent resides ike o be n will be
		es that included diabetes neuropathy (weakness,		potential to be affected, on 7-19-2	

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		345066	345066 B. WING				06/29/2023	
NAME OF P	ROVIDER OR SUPPLIER	•		STR	REET ADDRESS, CITY, STATE, ZIP CODE			
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DAVIDSO	N HEALTH & REHAB	CENTER		LEX	XINGTON, NC 27295			
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F 755	Continued From p	age 7	F7	755				
	numbness, and pa	ain from nerve damage) and			audit of the last 48 hours for all new			
		r disease (symptoms include			admissions was completed or availabi	lity		
	numbness and cra	,			of prescribed medications was comple			
					by the Director of Nursing. Any issues			
	Physician order da	ated 6/23/23 read pregabalin (a			were reported to the provider and			
	medication used to	o treat nerve and muscle pain)			pharmacy was contacted for medication	on		
	oral capsule 75 mi	illigrams (mg) by mouth two			availability.			
	times a day for pain related to peripheral vascular							
	disease. The start	date was 6/23/23 at 9:00 P.M.			What will you do to prevent this from			
					recurring or what systemic change wil	i you		
		nt #545's care plan initiated on			implement			
		focus area for potential for			To prevent this from recurring all licens	sed		
	·	s included administer			nurses and medication aides were educated by the Director of Nursing or	-		
		nterventions as ordered by for effectiveness, and notify			designee by 7-21-23 on facility protoc			
	medical doctor if in				for obtaining and administering	Ji		
	inoulour doctor in in	ionocavo.			medications for new admissions, as w	ell		
	Review of Resider	nt #545's Medication			as the protocol for medications that ar			
		cord (MAR) and progress notes igh 6/27/23 revealed the			unavailable.			
	pregabalin was do	cumented as administered/not			All new licensed nurses agency nurse	s,		
	administered as fo	ollows:			medication aides, and agency medica	tion		
	-On 6/23/23 a	t 9:00 P.M., the MAR showed			aides will receive this same education			
		alin was administered by Nurse			prior to working with residents			
		f "19" was documented on the						
		Other/ See Nurse Notes". The			How will you monitor and maintain			
	progress notes ha				ongoing compliance			
		00 A.M., the MAR showed no			To monitor and maintain ongoing			
		n was administered by Nurse f "19" was documented on the			compliance beginning 7-24-23. The Director of Nursing or designee will re	viou		
		Other/ See Nurse Notes". The			5 resident records per week for availa			
		cated the medication was on			of prescription medications following	Dility		
	order.	cated the initialization was on			admission. The audits will be complete	ed		
		00 P.M., the MAR showed no			for 12 weeks.			
		was administered by Nurse						
		f "19" was documented on the			QAPI			
		Other/ See Nurse Notes". The			The results of the audits will be forwar	ded		
	progress note indi	cated the medication was on			to the facility QAPI committee for furth	ier		
	order.				review and recommendations.			

Facility ID: 923187

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
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	NAME OF PROVIDER OR SUPPLIER DAVIDSON HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD LEXINGTON, NC 27295						
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F 755	Continued From pag		F 75	55						
	dose of pregabalin w #3. A chart code of " MAR to indicate "Oth	A.M., the MAR showed no ras administered by Nurse 19" was documented on the ner/ See Nurse Notes". The		Administrator is responsible for compliance.						
	order On 6/25/23 at 9:00 dose of pregabalin w #2. A chart code of "MAR to indicate "Oth progress note indicat received a prescriptic contacted and gave dose On 6/26/23 at 9:00 dose of pregabalin w #5 On 6/26/623 at 9:00 dose of pregabalin w #6. The progress not was not currently ava - On 6/27/23 at 9:00	P.M., the MAR showed no ras administered by Nurse 19" was documented on the ner/ See Nurse Notes". The ted the pharmacy had not on. The on-call physician was an order to hold tonight's A.M., the MAR showed a ras administered by Nurse of P.M., the MAR showed a ras administered by Nurse te indicated the medication ailable. A.M., the MAR showed a ras administered by Nurse te indicated the medication ailable. A.M., the MAR showed a ras administered by Nurse te indicated the medication ailable.		Date of compliance is 8-2-23.						
	pregabalin 75mg was 6/27/23. An observation on 6/ the automatic medical	ation receiving log showed is received by the facility on 29/23 at 7:35 A.M. revealed ation dispensing system was regabalin 50mg listed as								
	P.M. with Resident # Resident #545 indica medications she rece	nducted on 6/28/23 at 3:35 545. During the interview, ated she was unsure what eived from staff and if she edication for pain. Resident								

1, 1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 4748 OLD SALISBURY ROAD LEXINGTON, NC 27295	ZIP CODE	06/29/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BI O TO THE APPROPRIA CIENCY)	DATE
F 755	arrived at the facility, care with no concern. An interview was cor P.M. with Nurse #1. #545 arrived at the fa 6/23/23. Nurse #1 in who entered Resider into electronic medic her shift at 7 P.M. Nuentered the Resident she does not recall be did not have a prescipregabalin in her dischospital. The Nurse swas no prescription of pharmacy, she would director, who worked physician if the mediavailable. An interview was cor P.M. with Nurse #2. #2 indicated he was 6/23/23 from 7 P.M. #2 indicated Resider available for adminis P.M. During the interedid not contact the puthe pharmacy was gothern and the puther pharmacy was gothern and the puther pharmacy was gothern at the pharmacy was gothern at the puther pharmacy was gothern at the puther pharmacy was gothern at the pharmacy was gothern at the pharmacy was gothern at the puther pharmacy was gothern at the p	not had any pain since she and she completed her own s of pain. Inducted on 6/28/23 at 3:54 Nurse #1 recalled Resident acility the afternoon of dicated she was the nurse at #545's medication orders al record before the end of urse #1 explained when she at #545's medication orders, eing aware Resident #545 ription for her prescribed charge package from the stated, if she realized there or pregabalin to send to the di have contacted the medical until 8 P.M. or the on-call	F 7	755	JENCT)	
	to the on-coming nur pregabalin had not a there was an automa system on site at the pregabalin available	tion on his shift, he reported se Resident #545's rrived. The Nurse indicated tic medication dispensing facility that may have had for administration, but he did was unable to access the				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345066	B. WING			1	29/2023
	ROVIDER OR SUPPLIER	NTER		47	TREET ADDRESS, CITY, STATE, ZIP CODE 48 OLD SALISBURY ROAD EXINGTON, NC 27295	1 00/	23/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 755	Continued From page medication. During th		F	755			
	indicated the next tim #545, he observed Re was not available for administration. Nurse and was advised the a prescription to fill th contacted the on-call order to hold the med unsure of the date he about Resident #545' An interview was con A.M. with Nurse #4, a 6/24/23 from 7 P.M. to the interview, Nurse #4 she prepared Resided 9 P.M. administration #545's pregabalin was medication cart. Nurse documented the med she didn't have access medication dispension was available in the lo interview, Nurse #4 fo busy during her shift a physician for orders of about access into the dispensing system. N #545 had no complain An interview was atte was assigned to Resi AM. to 7 P.M. and ag to 7 P.M. shift but was	e he was assigned Resident esident #545's pregabalin the schedule 9 P.M. #2 contacted the pharmacy pharmacy had not received e medication. Nurse #2 physician and received an lication. Nurse #2 was contacted the pharmacy s prescription. ducted on 6/29/23 at 7:00 assigned Resident #545 on 6/25/23 at 7A.M. During #4 indicated on 6/24/23 as not #545's medications for the sunavailable in her e #4 indicated she lication was unavailable and as to the automatic g system to see if pregabalin bocked machine. During the authorities and did not contact the lor ask another staff member automatic medication was and did not contact the larther indicated she was and did not contact the larther indicated Resident must appear automatic medication was another staff member automatic member another staff member automatic member another staff member automati					
	A.M. with Nurse #5, a	ussigned Resident #545 on .M. and on 6/27/23 from 7					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C 06/29/2023	
		345066	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, Z		0/29/2023	
				4748 OLD SALISBURY ROAD			
DAVIDSON HEALTH & REHAB CENTER			LEXINGTON, NC 27295				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE CROSS-REFERENCED DEFICE)	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 755	Continued From page	e 11	F 7	755			
	A.M. to 7 P.M. During indicated when she w #545's medications for pass on 6/26/23 and Resident #545's preg medication cart. Nurse the automatic medication cart. Nurse the automatic medication epregabalin capsu #545. When asked w retrieved from the automatic medication accessed an inventor 50mg as available to 75mg was unavailable to 75mg was unavailable Nurse #5 indicated she wrong dose and sphysician for an order administer a dose difference of prescribed to the resinurse #5 indicated she physician on either dof 6/26/23, she wrote the physician communicates that referenced prescription for her putwice a day to be sensited. An interview was connurse #6, assigned from 7 P.M. to 6/27/2 indicated she was und #545 her scheduled of because the medication dispensing system. Note that the interview, Nurse saccess to medication dispensing system.	g the interview, Nurse #5 was preparing Resident or the 9 A.M. medication 6/27/23, she observed gabalin was not in the se #5 indicated she went to ation dispenser and retrieved ule to administer to Resident what dose of pregabalin she tomatic medication Jurse #5 indicated she was look. Nurse #5 went to the in dispensing system and ry list that showed pregabalin be dispensed, pregabalin le in the locked machine. The had given Resident #545 she should have called the into hold the medication or to ferent than the dose ident. During the interview, the had not called the ay. Nurse #5 indicated on the physician a note in the ation book kept at the nurse's Resident #545 needed a rescribed pregabalin 75mg at to the pharmacy. Inducted on 6/28/23 at with Resident #545 on 6/26/23					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345066	B. WING _			C 06/29/2023	
NAME OF PROVIDER OR SUPPLIER DAVIDSON HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		00/23/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 755	Continued From page	e 12	F 7	55			
	Nurse #6 indicated sl #545 to have any cor shift.	ce the mediation was did not due to being busy. he does not recall Resident mplaints of pain during her aducted on 6/28/23 at 5:02					
	P.M. with the Pharma indicated an electron #545's pregabalin wa Director and received	acist. The Pharmacist ic prescription for Resident as signed by the Medical by the pharmacy on The medication was filled,					
	sent to the facility, an Nurse #5 on 6/27/23 indicated staff had ac medication dispensin	nd signed as received by at 1:39 P.M. The Pharmacist coess to an automatic g machine on-site at the					
	and staff had the opti	ted with pregabalin 50mg from of ordering the in emergency pharmacy if					
	A.M. with the Medica Director indicated he reconciliation for all n either the day prior to	newly admitted residents o admission or the day the					
	residents were not al with a hard prescripti tried to identify at adr	d into the facility. He stated ways sent from the hospital on for medications and staff mission if a resident needed ledical Director indicated, if					
	his shift on Friday, 6/ entered a prescription Medical Director state	cted him prior to the end of 23/23, he would have n for Resident #545. The ed he worked in the facility					
	made him aware Res	rrsdays, and staff probably sident #545 needed a abalin on Monday, 6/26/23, acility. The Medication					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345066 NAME OF PROVIDER OR SUPPLIER DAVIDSON HEALTH & REHAB CENTER		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		B. WING _			C 06/29/2023		
			STREET ADDRESS, CITY, STATE, ZIP COD 4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		0.20.20.20		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 755	due on 6/23/23 at 9 fmedication was not a responsible to contact. The physician would order a different would order a different dose available in a different medication different medication I had on hand at the fathe Medical Director with an emergency psent the prescription determined the resid The Medical Director different dose of medication dose prescribed, start for an order prior to a The Medical Director caused to the resider doses or a lower dose administered. An interview was cornal A.M. with the Nurse interview, the Unit Maprescribed medication nurse should contact physician for addition indicated the physician medication for that directly medication the facility automatic medication sent for Unit Manager further	en the medication became P.M. and the schedule evailable, staff were et a physician for an order. either hold the medication, e if the medication was at dose from the automatic ag system, or order a chased on what the facility ecility. During the interview, indicated the facility worked harmacy that could have to them stat if it was eent needed the medication. further indicated if a lication was available in the in dispensing system from the ef should contact a physician administering the medication. indicated there was no harm int for the missed medication e of pregabalin being	F 7	55			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345066 B. WING				C		
NAME OF PR	ROVIDER OR SUPPLIER	0.0000		STREE	TADDRESS, CITY, STATE, ZIP CODE	1 06/	29/2023
DAVIDSON HEALTH & REHAB CENTER					OLD SALISBURY ROAD NGTON, NC 27295		
(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 755	when staff were unabin the machine, a supcontacted for assistar explained there were that had privileges in dispensing system to explained these indivithe nights shifts and owith user accounts if a nurse did not have medications in the local Manager further indical Resident #545 had no over the weekend. An interview conducte the Director of Nursin interview, the DON in #545's scheduled methe facility at an admiresponsibility to utilized dispensing system if was unavailable. The automatic medication have Resident #545's should have contacted pharmacy to obtain a physician should be dose to obtain new or physician. The DON of the surface was supplied to the surface was unavailable.	le to access the medication ervisor should have been noe. The Unit Manager several staff in the building the automatic medication set up user accounts. She duals were available during on weekends to access staff they had been made aware an active login to access the sked machine. The Unit ated she was unaware of received her pregabalin ated on 6/29/23 at 12:24 with g (DON). During the dicated when Resident dication was not available in instration time, staff had the exthe automatic medication the missing scheduled dose DON stated since the dispensing system did not a dose of medication, staff did the emergency back-up medication stat and/or the contacted about a missed ders, if any from the explained the nurse who	F	755			
F 760	paperwork from the hidentified Resident #5 sent to the pharmacy The DON did not prov #545 had not receive over the weekend.	45 and had her discharge ospital should have 45's needed a prescription to obtain her medication. Vide a reason why Resident d her prescribed medication	F	'60			8/2/23
SS=D							

PRINTED: 08/29/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C 06/29/2023	
	345066		B. WING _		0		
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP C		<u></u>	
D 41/11/2001		-NT-D		4748 OLD SALISBURY ROAD			
DAVIDSOI	N HEALTH & REHAB CI	ENIER		LEXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 760	Continued From page CFR(s): 483.45(f)(2)		F 7	760			
	medication errors.	sure that its- ents are free of any significant T is not met as evidenced					
	Based on record red Medical Director into prevent a significant administer a prescril a resident resulting i	view and resident, staff, erviews, the facility failed to medication error by failing to bed nerve pain medication to n six doses of medication of 1 resident (Resident #545) tion errors.		Problem F760 The facility failed proving her pain medication upon a 6/23/23, 6/24/23, and 6/25/ Corrective action for affects Resident number #545 no lin the facility.	dmission 23 ed resident		
	6/23/23 with diagnose mellitus with diabetic numbness, and pain peripheral vascular on numbness and cramples	ed 6/23/23 read Pregabalin (a reat nerve and muscle pain) grams (mg) by mouth two related to peripheral vascular ate was 6/23/23 at 9:00 P.M.		How will the facility identify residents that have the pote affected and what corrective done To identify other residents we potential to be affected on a udit was completed on all all controlled pain medicatic availability for the past 48 h Director of Nursing. Any issuer reported to the provide pharmacy was contacted for refills as needed. What will you do to prevent	who have the 7-19-2023, an residents with on for a lours by the sues identified er and or medication		
	admission note date "level of consciousno Orientation: alert and Review of Resident Administration Reco			recurring or what systemic implement To prevent this from recurring nurses were educated by the Nursing or designee by 7-2 protocol for obtaining and a medications for new admissions the protocol for medications.	ng all licensed ne Director of 1-23 on facility administering sions, as well		

Facility ID: 923187

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345066	B. WING _				29/ 2023	
NAME OF PR	ROVIDER OR SUPPLIER		1	S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2020	
DAVIDSO	N HEALTH & REHAB CE	NTER			748 OLD SALISBURY ROAD EXINGTON, NC 27295			
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 760	Continued From page	e 16	F 7	760				
F 760	Pregabalin was docu as follows: On 6/23/23 at 9:00 I dose of Pregabalin w #2. A chart code of "1 MAR to indicate "Oth progress notes had n - On 6/24/23 at 9:00 I dose of Pregabalin w #3. A chart code of "1 MAR to indicate "Oth progress note indicate order. On 6/24/23 at 9:00 I dose of Pregabalin w #4. A chart code of "1 MAR to indicate "Oth progress note indicate order. On 6/25/23 at 9:00 I dose of Pregabalin w #3. A chart code of "1 MAR to indicate "Oth progress note indicate order. On 6/25/23 at 9:00 I dose of Pregabalin w #3. A chart code of "1 MAR to indicate "Oth progress note indicate order. On 6/25/23 at 9:00 I dose of Pregabalin w #2. A chart code of "1 MAR to indicate "Oth progress note indicate "Coth progress note indicate "Oth progress n	P.M., the MAR showed no as administered by Nurse 9" was documented on the er/ See Nurse Notes". The	F	760	unavailable. All new licensed nurses, medication aides, and agency nurses will receive to same education prior to working with resident regarding facility processes by 8-2-23. How will you monitor and maintain ongoing compliance. To monitor and maintain ongoing compliance beginning 7-24-23. The Director of Nursing or designee will revisive 5 resident records per week for available of controlled pain medication following admission X 12 weeks. Any issues identified will be reported to the MD and pharmacy contacted as appropriate. QAPI The results of the audits will be forward to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance. Date of compliance is 8-2-23.	iew ility d		
	- On 6/26/623 at 9:00 dose of Pregabalin w #6. The progress not was not currently ava	P.M., the MAR showed a as administered by Nurse indicated the medication ilable.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		ONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345066	B. WING _			1	C 29/2023
NAME OF PROVIDER OR SUPPLIER DAVIDSON HEALTH & REHAB CENTER		1	474	EET ADDRESS, CITY, STATE, ZIP CODE 8 OLD SALISBURY ROAD KINGTON, NC 27295			
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page	e 17	F 7	760			
	Resident #545 indica had administered her weekend. Resident # experienced any pain the facility on 6/23/23 An interview was con P.M. with Nurse #2. [545 stated she had not since her admission into . ducted on 6/28/23 at 4:49 During the interview, Nurse					
	6/23/23 from 7 P.M. the stated when he primedications to be add P.M., Resident #545's available in the medical	_					
	medication later in his Resident #545's Preg end of his shift, and h on-coming nurse. Du indicated later that we 6/25/23 during the 7 I	s shift. Nurse #2 indicated pabalin had not arrived by the					
	schedule 9 P.M. med not available. Nurse # pharmacy and learne received a prescription	epared Resident #545's ications, her Pregabalin was #2 stated he contacted the d the pharmacy had not en. He contacted the on-call ed an order to hold Resident f Pregabalin.					
	A.M. with Nurse #4, a 6/24/23 from 7 P.M. t the interview, Nurse # when she prepared F for the 9 P.M. administregabalin was unaverse.	ducted on 6/29/23 at 7:00 assigned Resident #545 on o 6/25/23 at 7A.M. During #4 indicated on 6/24/23 desident #545's medications stration, Resident #545's ailable in her medication cart #4 stated she documented					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345066	B. WING				C 29/2023
NAME OF PROVIDER OR SUPPLIER DAVIDSON HEALTH & REHAB CENTER			4748	EET ADDRESS, CITY, STATE, ZIP CODE B OLD SALISBURY ROAD KINGTON, NC 27295	, , , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page	e 18	F	760			
	the medication being the information the of the shift report. Nurse had no complaints of An interview was atte was assigned to Resi AM. to 7 P.M. and ag to 7 P.M. shift but wa An interview was con Nurse #6, assigned F from 7 P.M. to 6/27/2 indicated Resident #8 scheduled dose of Pr the medication was n medication cart to be resident. Nurse #6 in Resident #545 to have during her shift. An interview was con A.M. with the Medica Director stated he wo Mondays and Thursd made him aware on 6 facility, Resident #54 Pregabalin and need medication to filled by Director indicated who due on 6/23/23 at 9 F medication was unav responsibility to conta The Medical Director.	on order because that was f-going nurse told her during at #4 stated Resident #545 pain during her shift. Impted with Nurse #3 who ident #545 on 6/24/23 from 7 ain on 6/25/23 from 7 A.M. sunsuccessful. ducted on 6/28/23 at with Resident #545 on 6/26/23 at 7 A.M. Nurse #6 at 7 A.M. Nurse #6 at 7 A.M. because of available in the administered to the dicated she does not recall the any complaints of pain ducted on 6/29/23 at 10:51 Director. The Medical arked in the facility on ays, and staff probably 5/26/23, when he was in the 5 had not received her ed a prescription for the 7 pharmacy. The Medication en the medication became P.M. and the scheduled					
		ducted on 6/29/23 at 11:54					
	A.M. with the Nurse N	/Janager. During the					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345066	B. WING		C 06/29/2023
	DAVIDSON HEALTH & REHAB CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		1 00/23/2020
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 760	prescribed medication scheduled medication nurse should contact physician for addition further indicated she had not received her weekend. An interview conduct the Director of Nursing interview, the DON in #545's scheduled met the facility at an admiresponsibility to utilized dispensing system if was unavailable or coback-up pharmacy to and/or the physician missed dose to obtain not provide a reason received her prescribe weekend. The DON different dose was in dispensing system. Required In-Service CFR(s): 483.95(g)(1) §483.95(g)(1) Be surcontinuing competer be no less than 12 here.	anger indicated when a on was not available for a n administration time, the at the physician or the on-call hal orders. The Unit Manager was unaware Resident #545 Pregabalin over the ded on 6/29/23 at 12:24 with hig (DON). During the hidicated when Resident edication was not available in inistration time, staff had the determinent the missing scheduled dose ontact the emergency obtain a medication states should be contacted about a noneworders. The DON did why Resident #545 had not be ded medication over the confirmed Pregabalin at a the automatic medication. Training for Nurse Aides O-(4) in-service training for nurse designed in the confirmed pregabalin at a the automatic medication. Training for Nurse Aides O-(4) in-service training for nurse designed in the confirmed pregabalin at a the automatic medication.	F 9		8/2/23
		e dementia management abuse prevention training.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED	
		345066	B. WING _			C 06/29/2023
NAME OF PROVIDER OR SUPPLIER DAVIDSON HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODI 4748 OLD SALISBURY ROAD LEXINGTON, NC 27295	E	00/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 947	determined in nurse and facility assessm address the special determined by the face special determined by: Based on record respecial file of the facility filed to provid management training assistants (NA) review the findings included Paper documents prindicated NA#1 was new hire orientation conducted 5/25/2023 NA#1 received training managing residents. Attempts to contact of the face special determined by the face special deter	as areas of weakness as aides' performance reviews ent at § 483.70(e) and may needs of residents as cility staff. Arse aides providing services ignitive impairments, also the cognitively impaired. To is not met as evidenced for required dementia in the formal for 1 of 5 (NA#1) Nurse ewed for required training. Arich May 24, 2023. NA#1's and onboarding was indication in the following on dementia care or with dementia. NA#1 were not successful. Man interview was director of Nursing (DON). been employed at the facility	F9	Problem F947 Facility failed to provide Dementia training prior to wor residents. Corrective action for affected Certified Nursing Assistant #1 dementia training on 7-13-202 How will the facility identify otl residents that have the potent affected and what corrective a done An audit was conducted on 7- the human resources director for completion of dementia tra staff identified have completed dementia training by 7-18-202	resident completed 23. her like action will be action will staff ining. All d their 23.	
	training was not part She further stated sh	e was not aware dementia of the new hire orientation. ne called corporate and training be added to the new		What will you do to prevent the recurring or what systemic chainplement. To prevent this from recurring resources director was educated 7-14-2023, by the administrate requirement for all staff to recurrence demential training during new	ange will you the human ted or on the eived	J

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345066 B. WING					29/ 2023	
NAME OF P	ROVIDER OR SUPPLIER	3.000		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 06/	29/2023
					48 OLD SALISBURY ROAD		
DAVIDSON HEALTH & REHAB CENTER				EXINGTON, NC 27295			
(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 947	Continued From page	÷ 21	FS	947	orientation. All new hires will receive dementia education during new hire orientation prior to working with resider All new human resources directors will receive this same education prior to participating in new hire orientation All new staff and agency staff will receive dementia orientation prior to working with residents How will you monitor and maintain ongoing compliance To monitor and maintain ongoing compliance beginning 7-24-2023. The administrator or designee will review 5 staff records per week for completion of Dementia training for 12 weeks. QAPI The results of the audits will be forward to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance. Date of compliance is 8-2-2023.	ved ith f	