PRINTED: 02/07/2024 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		
		345356	B. WING _				C <b>28/2023</b>
	ROVIDER OR SUPPLIER  JARE NURSING & REH	IAB		300	REET ADDRESS, CITY, STATE, ZIP CODE O NORTH MAIN STREET CH SQUARE, NC 27869	1 12	20,2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F	000			
	from 12/19/23 to 12/ information received 12/22/23. Onsite va jeopardy removal pl 12/28/23. Therefore Event ID #48ST11.	gation was conducted onsite /20/23 with additional differential remotely on 12/21/23 and alidation of the immediate ans was conducted on e, the exit date was 12/28/23.					
	NC00211011 and N Both intakes resulte	es were investigated: C00210781. d in immediate jeopardy. allegations resulted in					
	(J)	580 at a scope and severity					
	(K)	F684 at a scope and severity					
	(K)	F689 at a scope and severity					
	(K)	F726 at a scope and severity F755 at a scope and severity					
	(K)	760 at a scope and severity					
	` '	F835 at a scope and severity					
	The tags F684, F68 Substandard Quality	9, and F760 constituted y of Care.					
	11/1/23 and was rer Immediate Jeopardy	y for F689 and F726 began on moved on 12/22/23. y for F755 and F760 began on emoved on 12/22/23.					
ARODATORY	NIDECTOR'S OR PROVINCE	R/SUPPLIER REPRESENTATIVE'S SIGNATU	IDE		TITI F		(X6) DATE

Electronically Signed 01/29/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345356	B. WING			1	C <b>28/2023</b>
	ROVIDER OR SUPPLIER  JARE NURSING & REHA	AB		3	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH MAIN STREET RICH SQUARE, NC 27869		
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	and was removed on Immediate Jeopardy and was removed on	for F684 began on 12/4/23 12/22/23. for F580 began on 12/4/23 12/23/23. for F835 began on 11/1/23 12/23/23.	F	000			
F 580 SS=J	Notify of Changes (In CFR(s): 483.10(g)(14) §483.10(g)(14) Notific (i) A facility must immonsult with the residuant consistent with his or representative(s) who (A) An accident involvesults in injury and helphysician intervention (B) A significant changemental, or psychosocideterioration in health status in either life-th clinical complications (C) A need to alter the a need to discontinue treatment due to advocommence a new for (D) A decision to transesident from the facility when making notic (14)(i) of this section, all pertinent informatic is available and proviphysician.  (iii) The facility must a	cation of Changes. dediately inform the resident; ent's physician; and notify, her authority, the resident en there isving the resident which has the potential for requiring an; age in the resident's physical, sial status (that is, an, mental, or psychosocial reatening conditions or an existing form of erse consequences, or to m of treatment); or sfer or discharge the	F	580			1/26/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345356	B. WING _			C <b>12/28/2023</b>	
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869		12/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SHORT CROSS-REFERENCED TO THE APDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 580	as specified in §483 (B) A change in res State law or regulat (e)(10) of this sectic (iv) The facility mus update the address phone number of the representative(s).  §483.10(g)(15) Admission to a composite §483.5) must disclosite physical configurations that composite systems and must spectroom changes betwoeder §483.15(c)(9) This REQUIREMENT Based on record reand physician, the suphysician of a mediate of the physician of a mediate of seizure actincidents of seizure actincidents of seizure 12/5/23. Emergence contacted and the remergency Room (anti-seizure medic resident had no furfreceiving Vimpat ar facility the same daresidents (Resident of change.	m or roommate assignment 3.10(e)(6); or ident rights under Federal or cions as specified in paragraph on.  It record and periodically (mailing and email) and he resident  Inposite distinct part. A facility distinct part (as defined in see in its admission agreement ration, including the various rise the composite distinct bify the policies that apply to ween its different locations ).  In is not met as evidenced eview and interviews with staff facility failed to notify the cal emergency when Resident in its part of the cal emergency when Resident in its part of the cal emergency when Resident in its part of the cal emergency when 12/4/23 and y Medical Services (EMS) was resident was transported to the	F 5	F 580  1. How corrective action will be accomplished for resident(s) four have been affected; Resident #3 identified as being affected by the noncompliance. The DON notified facility Medical Director of the in 12/5/23. Nurse #1 and nurse #2 removed from the facility.  2. Identify other residents who potential to be affected: The DON and Minimum Data Senurse evaluated all residents to any changes in condition. No accompliance in status.  3. What measure will be put in	and to 3 was ne ed the icident on were to have the et (MDS) identify iditional significant		

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NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	12/20/2020
				300 NORTH MAIN STREET	
RICH SQI	JARE NURSING & REH	AB		RICH SQUARE, NC 27869	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
F 580	Continued From pag	e 3	F 58	0	
	Resident #3 had seiz	rure activity. The immediate		systemic changes made to ensure	that
	jeopardy was remove	ed on 12/23/23 when the		the identified issue does not occur	in the
	facility provided an a	cceptable credible allegation		future:	
	for immediate jeopar	dy removal. The facility will		All full-time, part-time, prn, and age	
		ance at a lower scope and		licensed nurses and medication aid	les
	•	(no actual harm with potential		were educated by the DON on cha	
		al harm that is not immediate		condition and physician notification	
		completion of education and		regulations per facility policy and	
		ms put into place are		procedure beginning 12/21/23. No	
	effective.			licensed nurse or medication aide	
				work until education has been com	
	The findings included	1:		Nurses are to contact physician via	•
	Booldont #2 was adn	nitted to the facility on 3/2/22		immediately when resident physica	
		nitted to the facility on 3/2/23 e facility on 11/13/23 with		mental condition is changed from band additional interventions may be	
		uded traumatic subdural		required. This includes abnormal	-
		disorder/epilepsy, traumatic		behavior, vital signs, physical chan	nes in
		trostomy status (a tube		movement or body function or	903 111
	surgically placed into			consciousness such as lethargy or	
	cangisany places into			seizures. " All full-time, part-time, p	rn. and
	A nurse's note writter	n bv Nurse #2 dated		agency nurse aides and medication	
		revealed that Resident #3		were educated by the DON on repo	
		ng having seizure activity by		observed changes in residents' cor	
		Nurse #2 indicated when		to licensed nurses beginning 12/22	/23. No
	she arrived to his roo	om the resident was not		nurse aide will work until education	has
		vity but wasn't answering		been received. " All newly hired and	d
		uld normally do. The note		agency staff (licensed nurses, nurs	
		staff stayed by his side until		aides, and medication aides) will be	e
		tely alert and responding like		educated on change of condition a	
		was in stable condition and		physician notification regulations pe	
	hadn't shown anymo	re seizure activity as of yet.		facility policy and procedure, accor	
				in orientation prior to working the fl	
		nentation in Resident'#3's		Human resources will ensure the p	acket
		he physician was notified of		is complete.	_
	his seizure activity or	า 12/4/23.		4. Indicate how the facility plans	
				monitor its performance to make su	
		nducted with agency Nurse		the deficient practice does not reod	
		:33 am who worked with		The Director of Nursing /designee	
	Resident #3 on 12/04	1/23. She stated staff		audit the twenty-four-hour summar	v report

Facility ID: 923433

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345356	B. WING		1	C <b>2/28/2023</b>	
	ROVIDER OR SUPPLIER  UARE NURSING & REHA	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	and when she arrived observe seizure active the Director of Nursir Resident #3 and commake sure he was alt 12/04/23.  A nurse's note writter 10:14 am revealed resigns or symptoms or discomfort. Alert to phathed and shaved resigns or symptoms or discomfort. Alert to phathed and shaved resigns are sident diapproximately 2 minuagain at 10:10 am who DON notified. Will no contact.  An interview was compm with Nurse #1. Nowas in the facility main and as she passed he Resident #3's seizure told staff to administe stated on 12/05/23 are Resident #3's contractill, for a minute and Nurse #1 indicated sit 12/05/23 Resident #3' Vimpat was not avail physician ordered Ati She stated they could staff had access to the storage. Nurse #1 staphysician said to sen A nurse's note writter	was having seizure activity d to his room, she did not vity. Nurse #2 stated she and ng (DON) stayed with tinued to monitor him, to ert and at his baseline on n by Nurse #1 on 12/05/23 at esident resting in bed no	F 58	in clinical morning meeting 5 t for twelve weeks. The Administ discuss the audit results with the during the monthly Quality Assembler Performance Improvement meathree months. The audits will be to ensure compliance is ongoing determine whether there is a refurther audits, re-education, or modification.	strator will the IDT surance eeting for be reviewed ing and will need for		

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	ROVIDER OR SUPPLIER  UARE NURSING & REH	АВ	;	STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	12/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 580	Resident #3 had 3 e with the last event at the last event at The Medical Directo 12/19/23 at 1:58 pm he could not recall the stated that due to the to give the resident I facility staff could not he sent Resident #3 He stated he could revailability of Resident The EMS Report dad dispatch received the arrived at the facility informed EMS Resident He hospital per physically not having the (Vimpat). When asked seizures the nurse in seizures on this date 8:18 am, 10:10 am, the facility at 3:25 pm at 3:56 pm. No seizutransport. While givin nurse Resident #3 we seizure.  The hospital record Resident #3 present history of seizures, I date and had been ce (11/24/23). He was responsive but confirmation.	ty. The note indicated pisodes of seizure activity to 1:47 pm.  It was interviewed on and 2:16 pm. He indicated the exact date, but he was told to the the triangle of the seizure activity. He eseizure activity he wanted to the the triangle of the Ativan so out to the ER for evaluation.	F 580			

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	ROVIDER OR SUPPLIER	НАВ	3	STREET ADDRESS, CITY, STATE, ZIP CODE 800 NORTH MAIN STREET RICH SQUARE, NC 27869	12/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION	
F 580	noted. The record reports medication the pharmacy emph [Resident #3] gettin prescribed" Resilisted as seizures, sonocompliance with the DON who is call the physician wobserved with seizure physician.  The Administrator with geopardy on 12/20/27. The facility provided jeopardy removal point of the noncompliance. The facility failed to Resident #3 was idented the noncompliance. The facility failed to Resident #3 had seapproximately 2:30 approximately 8:18. Resident #3 had 4 is the following approximately approximately 2:30 approximately 8:18.	on further seizure activity was stated, "Spoke with facility, has not been picked up from nasized importance of g his medications as ident #3's diagnoses were seizure disorder, and nadication regimen.  Onducted on 12/20/23 4:33 pm andicated staff should always then any resident was are activity and notify the was notified of immediate 23 at 5:21 pm.  If the following immediate lan:  Spipients who have suffered, or a serious adverse outcome as ompliance; entified as being affected by and on 12/5/23 at PM and on 12/5/23 at AM.  Incidents of seizure activity on eximate dates and times 1, 12/5/23 at 8:18 AM, 12/5/23	F 580			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345356	B. WING			C   <b>2/28/2023</b>	
	ROVIDER OR SUPPLIER  UARE NURSING & REHA	I		STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH MAIN STREET RICH SQUARE, NC 27869		212012023	
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F 580	Continued From page	e 7	F 5	80			
	of the incident on 12/ " The DON and M nurse evaluated all re changes in condition were identified with a on 12/21/23. " The DON remove were aware of signification and process or system fare adverse outcome from when the action will be " All full-time, particensed nurses and educated by the DON physician notification and procedure beginn nurse or medication and physician via phone in physician via phone in physician or mental control of the physician of the includes in the physician of the includes in the includes in the includes in the includes in the incidental of	inimum Data Set (MDS) esidents to identify any No additional residents significant change in status  ed the licensed nurses who cant change, but did not ian, from returning to the removed on 12/8/23 and ed on 12/20/23.  the entity will take to alter the filure to prevent a serious m occurring or recurring, and					

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		TE SURVEY
		345356	B. WING _			C 12/28/2023
	ROVIDER OR SUPPLIER  JARE NURSING & REHA	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869		12/20/2020
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F 580	be educated on chan physician notification and procedure, accor working the floor. Hur packet is complete.  Alleged date of immed 12/23/23  Onsite validation of the removal plan was comphysician was notified and the evaluations of Nurse and DON were concerns. Nurse #1 afrom the facility as incomproved on changes notification aides comprovided on changes notification regulation procedure. The procedure. The procedure. The procedure and addrequired. Education via resident physician via resident physici	and medication aides) will ge of condition and regulations per facility policy rdingly in orientation prior to man resources will ensure ediate jeopardy removal:  The immediate jeopardy inducted on 12/28/23. The inducted on 12/28/23. The inducted of all residents by the MDS is verified and revealed no and Nurse #2 were removed dicated. In service records incensed nurses and firmed education was inducted of condition and physician is per facility policy and edure is for nurses to phone immediately when mental condition is changed ditional interventions may be was also confirmed for nurse in aides on reporting residents' condition to cation as noted was added Human Resources Director suring the education is	F 5	30		
F 684 SS=K	Quality of Care CFR(s): 483.25 § 483.25 Quality of ca	are	F 6	34		1/26/24
	3 TOO.20 Quality of G	ai <del>u</del>				

AND BLAN OF CORRECTION INTEREST INCIDENTIFICATION NUMBERS			` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345356	B. WING _			C / <b>28/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER		<del>'</del>	STREET ADDRESS, CITY, STATE, ZIP CODE		720/2020	
TO THE OT THE	TO VIDER ON OUT FEET						
RICH SQL	JARE NURSING & REHA	B		300 NORTH MAIN STREET			
				RICH SQUARE, NC 27869			
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F 684	Continued From page	9	F 6	84			
	Quality of care is a fu	ndamental principle that					
	_	nt and care provided to					
		ed on the comprehensive					
	-	dent, the facility must ensure					
		treatment and care in					
	accordance with profe						
		ensive person-centered					
	care plan, and the res						
	This REQUIREMENT	is not met as evidenced					
	by:						
	Based on record revi	ew and interviews with staff,		F 684			
	Emergency Medical S	Services (EMS) personnel,		How corrective action will be			
	pharmacist, and phys	ician, the facility failed to		accomplished for resident(s) found	to		
	identify the seriousne	ss of seizure activity on		have been affected. Resident # 3	√as		
	12/4/23 and the need	for medical intervention for		sent to the hospital on 12/05/23 ar	d		
	a resident with a histo	ory of seizures who had not		received seizure medication.			
	been provided with hi	s anti-seizure medication		The Director of Nursing removed t	ıe		
	,	23. Resident #3 had four		licensed nurses who were aware of	f the		
		ctivity between 12/4/23 and		resident's seizure but did not seek			
	12/5/23. Following the	e fourth seizure (12/5/23) the		treatment interventions, from retur	ing to		
	physician ordered Ativ			facility.			
	medication commonly			Identify other residents who	iave		
		es) via intramuscular (IM)		the potential to be affected.			
		ity staff were unable to		On 12/20/23 the Director of Nursin	•		
	_	y Ativan medication supply		floor nurses evaluated all residents			
		the facility. Emergency		no other residents identified as ne	ding		
		IS) was contacted, and the		medical interventions.			
		ted to the Emergency Room		3. What measures will be put in	-		
		B experienced a fifth seizure		to ensure the identified issue does	not		
	upon arrival in the em	, ,		occur in the future?			
		oat was administered in the		All licensed nurses including agen			
	ER and the resident h			were educated by the DON on ide			
		narged back to the facility the		what is a medical emergency and			
		red for 1 of 2 residents		need to provide the necessary car	and		
		ired Emergency Medical		services for residents who require	anin a		
	Services.			emergency medical services. Begi			
	Immediate Issues	hagan an 12/01/22h == th =		12/21/23 the Administrator, DON,			
		began on 12/04/23 when the by the seriousness of seizure		Staffing Coordinator will ensure no is permitted to work prior to complete			

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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		0/2023	
				300 NORTH MAIN STREET			
RICH SQI	JARE NURSING & REHA	λB		RICH SQUARE, NC 27869			
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F 684	Continued From page	e 10	F 6	84			
F 684	activity for a resident The immediate jeopa 12/22/23 when the fa credible allegation for removal. The facility of at a lower scope and actual harm with pote harm that is not immediate completion of educati systems put into place The findings included  Resident #3 was adm 10/09/23 and readmit 11/13/23 with diagnost traumatic subdural hed disorder/epilepsy, traig gastrostomy status (atthe stomach).  Review of the signific Set (MDS) dated 10/2 as having moderately MDS coded the resid disorder/epilepsy and status.  A nurse's note written 12/04/23 at 2:30 pm r was seen this mornin staff during this shift. she arrived at his roo showing seizure activ questions like he wou stated Nurse #2 and the resident was com like normal. Resident	with a history of seizures. rdy was removed on cility provided an acceptable immediate jeopardy will remain out of compliance severity level of a E (no ential for more than minimal ediate jeopardy) to ensure on and that monitoring e are effective. : initted to the facility on ted to the facility on ses which included, emorrhage, seizure umatic brain injury, in tube surgically placed into ant change Minimum Data 15/23 identified the resident impaired cognition. The	F 6	education. " Education inchanges in resident cond a medical emergency such breathing, loss of conscious eizures, injuries and othe Beginning 12/21/23 all nelicensed nurses, including will be educated on what emergency and the need necessary care and serving who require emergency mas part of their orientation the floor. The Human Residual ensure each nurse has was informed of the task Administrator on 12/21/23.  4. Indicate how the facility its performance to make adeficient practice does not the Director of Nursing / audit the twenty-four-hou in clinical morning meeting for twelve weeks.  The Director of Nursing / I audit the Medication not / I report in clinical morning a week for twelve weeks. Administrator will discuss with the IDT during the massurance Performance meeting for three months be reviewed to ensure coongoing and will determing is a need for further audit or modification.	ition that indicate ch as difficulty busness, onset of er examples. " ewly hired g agency staff, is a medical to provide the ces for residents nedical services in prior to working sources Director as completed and by the 3. In plans to monitor sure that the of reoccur: designee will resummary reporting 5 times a week  Designee will Administered meeting 5 times The the audit results onthly Quality Improvement The audits will impliance is ne whether there		
	stated Nurse #2 and the resident was com like normal. Resident	staff stayed by his side until pletely alert and responding #3 was in stable condition		I	s, re-cuulation,		

Facility ID: 923433

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  UARE NURSING & REI	HAB	30	TREET ADDRESS, CITY, STATE, ZIP CODE DO NORTH MAIN STREET ICH SQUARE, NC 27869	12/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 684	#2 on 12/19/23 at 1 Resident #3 on 12/1 pm. Nurse #2 state nurse aide reported seizure activity and she did not observe stated she stayed w to monitor him, to n his baseline on 12/0 An interview was co Aide #1 on 12/19/2 Aide #1 revealed th on 12/05/23 his arm body for 10 second she reported the ind who was agency st  A nurse's note writt 10:14 am revealed signs or symptoms discomfort. Alert to bathed and shaved 8:18 am. Resident of approximately 2 min again at 10:10 am w DON notified. Will r contact.  An interview was co pm with Nurse #1. I 11/27/23 she texted prescription reques physician to sign ar refill. Nurse #1 state on Tuesday 12/05/2 medication cart. Sh	onducted with agency Nurse 1:33 am who worked with 04/23 from 7:00 am to 3:00 and she did not recall which Resident #3 was having when she arrived in his room, a seizure activity. Nurse #2 with Resident #3 and continued make sure he was alert and at 04/23.  onducted with Rehabilitation at while bathing Resident #3 as drew tight up against his as then ended. She indicated cident to the nurse (Nurse #1) aff.  en by Nurse #1 on 12/05/23 at resident resting in bed no	F 684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345356	B. WING _			C 12/28/2023
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH MAIN STREET RICH SQUARE, NC 27869	E	12/20/2020
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 684	of Resident #3's seizindicated the physicing given to Resident #3 DON began to search in the facility. She indicated supply with medication supply with medication dispensification dispensification dispensification. She stated on observed Resident #stiff, he got still, for a was okay. Nurse #1 Vimpat available, state emergency medication called EMS and the resident out to the E.  A progress noted eminote dated 12/05/23 recurrent seizure act history of seizure districted to recover in b. He was at high risk for recurrent seizure act between seizures) in on valproic acid (ant treatment of epilepsy. Director indicated du made the decision to local emergency depwork up secondary to this morning.  Resident #3's Medicon 12/19/23 at 1:58 indicated he could not supplied to the seizure of the secondary to the secondary t	assed him in hall notified him ture activity. Nurse #3 an then ordered Ativan be . Nurse #1 indicated the h and found no Vimpat was dicated the emergency as stored in a secure ng machine and none of the ON, had access to pull the n 12/05/23 at 1:47 pm, she is scontracted arm became in minute and then he said he stated as there was no set off could not access the on supply for Ativan, she physician said to send the R.  Itered by the Medical Director revealed Resident #3 had ivity on 12/05/23 with known order. The resident was etween the seizure episodes. For status epilepticus (a ivity without recovery inpending. He was currently is convulsant used in the order plus Vimpat. The Medical lee to clinical condition he or transfer Resident #3 to the partment for further definitive or recurrent seizures since	F	884		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		<b>345356</b> B. WING			C 12/28/2023		
	NAME OF PROVIDER OR SUPPLIER  RICH SQUARE NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP COI 300 NORTH MAIN STREET RICH SQUARE, NC 27869		1 1220/2020	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	stated the facility staf Ativan, so he sent Re evaluation. He stated the availability of Res The EMS Report date dispatch received the resident with seizures at the facility at 2:57 pm at 3:57 pm at 3:56 pm. No seizures on this date 8:18 am, 10:10 am, at the facility at 3:25 pm at 3:56 pm. No seizures on this date 8:18 am, 10:10 am, at the facility at 3:25 pm at 3:56 pm. No seizures on this date 8:18 am, 10:10 am, at the facility at 3:25 pm at 3:56 pm. No seizures, Resident #3 w seizure.  A telephone interview at 12:48 pm with EMS when he arrived in the no staff available to grequest nursing staff #1 reported that Resito the hospital per ph facility not having the (Vimpat). EMS #1 st. Resident #3 went 4 to Resident #	e resident IM Ativan. He f could not get access to esident #3 out to the ER for he could not comment on sident #3's Vimpat.  ed 12/05/23 indicated	F 68				

_ ` · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345356	B. WING			C	
	NAME OF PROVIDER OR SUPPLIER  RICH SQUARE NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  300 NORTH MAIN STREET  RICH SQUARE, NC 27869		12/28/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	Continued From pa	ge 14	F 6	84			
	Resident #3 preser history of seizures, date and had been (11/24/23). He was responsive but con indicated he was trolly (intravenous), ar was noted. The refacility, reports medicated up from the importance of [Resmedications as president in the importance of the i	I dated 12/05/23 revealed ated on 12/05/23 for prior had three seizures on this out of Vimpat since Friday noted as alert, verbally fused. The hospital report eated with Vimpat 200 mg via and no further seizure activity cord stated, "Spoke with dication (Vimpat) has not been pharmacy emphasized ident #3] getting his scribed" Resident #3's eed as seizures, and seizure					
	pm revealed Reside hospital with no new A phone interview of 1:20 pm with the faindicated Resident Vimpat ran out on a was sent to the ER Pharmacist stated to	was conducted on 12/28/23 at cility Pharmacist #1. She #3's MAR documented the 11/25/23 and on 12/05/23 he for seizure activity. The that abruptly stopping the Resident #3 would have the					
	am with the facility's position on 11/27/2 first made aware or Resident #3's Vimp administration and She stated it was a ordered IM Ativan of	onducted on 12/20/23 at 10:16 s current DON who took the 3. The DON reported she was a 12/04/23 by Nurse #2 that eat had not been available for called the pharmacy that day. Ifter lunch when the physician on 12/05/23, no staff in the to the emergency medication					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345356	B. WING		12/28/2023
	NAME OF PROVIDER OR SUPPLIER  RICH SQUARE NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	, 12/25/2020
(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 CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO
F 684	Continued From pag	ge 15	F 68	4	
	stated the physician	t access the Ativan. The DON saw Resident #3 on 12/05/23 esident continued to have nout.			
	with the DON who in call the physician who observed with seizur physician when any not available. The D to make sure they hadicated she was not available or nurses to monitor Refurther seizure activities.				
	jeopardy on 12/20/2	as notified of immediate 3 at 1:47 pm. the following immediate			
	jeopardy removal plants.  1. Identify those result or are likely to suffer as a result of the no	ecipients who have suffered, r, a serious adverse outcome ncompliance. identify the seriousness of			
	medical intervention of seizures who had anti-seizure medical The facility did not h facility and did not h emergency medicati resident in the facilit	2/4/23 and the need for for a resident with a history not been provided with his ion (Vimpat) since 11/25/23. ave Vimpat available in the ave access to their on supply to treat the y. EMS was not contacted d his fourth incident of			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG	(X3)	(X3) DATE SURVEY COMPLETED	
		345356	B. WING _			C <b>12/28/2023</b>	
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(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From page seizure activity.  Resident #3 was ide deficient practice.  All residents were at practice.  Upon evaluation by to other residents were medical interventions.  2. Specify the activate process or syste adverse outcome frowhen the action will  "The DON removers aware of the reseek further treatmereturning to the facility. All licensed nurse were educated by the a medical emergency require emergency residents."	ntified as affected by the risk from the deficient the floor nurses and DON no identified as needing s on 12/20/23. on the entity will take to alter m failure to prevent a serious m occurring or recurring, and					
	work prior to comple "Education includeresident condition the emergency such as consciousness, onseto other examples. "Beginning 12/21 nurses, including agon what is a medical provide the necessal.	des identifying changes in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  JARE NURSING & REHA	L		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	12/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
	services as part of the working the floor. The will ensure each nurs informed of the task is 12/21/23.  Alleged date of imme: 12/22/23  Onsite validation of the removal plan was conevaluations of all resinand DON were verified concerns. Nurse #1 afrom the facility as incand interviews confirmon: identifying what the need to provide the services for residents medical services. The orientation and the Horesponsible for ensuring education prior to work immediate jeopardy rows validated.  Free of Accident Haza CFR(s): 483.25(d) (1) (1) (1) (2) (4) (2) (2) (3) (2) (3) (4) (3) (4) (4) (4) (4) (5) (5) (6) (6) (6) (7) (7) (7) (7) (7) (7) (7) (7) (7) (7	eir orientation prior to Human Resources Director e has completed and was by the Administrator on  diate jeopardy removal  diate jeopardy removal  die immediate jeopardy nducted on 12/28/23. The dents by the floor nurses ed and revealed no and Nurse #2 were removed dicated. In service records med education was provided is a medical emergency and me necessary care and who require emergency is education was added to uman Resources Director is ing each nurse receives the rking on the floor. The emoval date of 12/22/23  ards/Supervision/Devices (2)	F 68		1/26/24

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BUILDII	A. BOILDING				
		345356	B WING	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	343300	5:	C-	TREET ADDRESS CITY STATE ZID CODE	1 12	2/28/2023	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
RICH SQI	JARE NURSING & REI	HAB			00 NORTH MAIN STREET			
				R	RICH SQUARE, NC 27869			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 689	Continued From pa	ge 18	F	689				
. 000	-	-		509	F 600			
		tion, record review, interviews f, dialysis center nurse, and			F 689  1. How corrective action will be			
		I Services staff, the facility fe transportation in the facility's			accomplished for resident(s) found to have been affected.			
		and to ensure wheelchairs			Resident # 1 was seen evaluated by E	:MC		
		transportation in accordance			with no injuries noted. Resident #2 wa			
	with manufacturer's			discharged from the facility on 12/08/2				
	residents reviewed			TA #1 was terminated on 12/04/23.	<b>.</b>			
	and Resident #2).			All residents who are transported	in			
	Assistant #1 utilized			the facility van were identified to				
	chair with a wheele			potentially be affected by the deficient				
		portation the resident slid out			practice.			
	of the chair onto the			3. What measure will be put in place	e or			
	was not injured. Or	n 11/27/23 Transportation			systemic changes made to ensure tha	t		
	Assistant #1 did no	t buckle Resident #2's seatbelt			the identified issue does not occur in the	ne		
		rtation the resident fell out of			future?			
		onto the floor of the van.			The current transportation aide has			
		ed pain in her right shoulder			reviewed the facility's policy on			
		hese incidents had the high			transportation and completed an			
	likelihood of serious	s harm, injury or death.			in-service on 12/21/23 regarding the			
		444400			safety and securement of all residents			
		y began on 11/1/23 when			being transported in the facility			
		stant #1 transported Resident			transportation van, with a return			
	in a geriatric cha	hir (geri chair #1) that was not			demonstration observed by the			
		e resident fell out of the chair.			Maintenance Director.  The facility will utilize wheelchairs in pl	1000		
					of geri-chairs when transporting reside			
		pardy was removed on facility provided an acceptable			or use a medical transportation compa			
		of immediate jeopardy			when needed.	шу		
		y remains out of compliance at			The transportation aide was educated	on		
		severity of E (no actual harm			ensuring residents are transferred to			
		ore than minimal harm that is			proper chairs for transportation and the	at		
	•	ardy) to ensure education and			geri-chairs are not proper chairs on			
		put into place are effective.			12/21/2023 by the Maintenance Direct	or.		
		•			Beginning 12/21/23 all transport aides			
	The findings include	ed:			receive safety training upon hire and			
					annually. Training will be conducted by	/ the		
	1. Review of the 4-	point securement system's			Maintenance Director and will include			
		al (undated) found on the			return demonstration of competency.	īhis		

Facility ID: 923433

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345356	<b>345356</b> B. WING			C <b>12/28/2023</b>		
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		12/2	LO/ LOLO	
DIOL OO	LADE MUDOINO A DELLA			300 NORTH MAIN STREET				
RICH SQUARE NURSING & REHAB				RICH SQUARE, NC 27869				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 689	Continued From page	e 19	F 68	39				
	website included the system should only b wheelchair. Resident #1 was adm	n van's manufacturer's following information: the e used on front-facing nitted to the facility on esis that included end stage		training will involve a review of transportation policy, an in-serving regarding the safety and secure residents being transported in transportation van, and supervineeded.  4. Indicate how the facility pl	vice ement of the facilit ision as			
	assessment dated 12 cognitively intact. He was assessed as dep Resident #1 utilized a received dialysis.	rly Minimum Data Set 2/1/23 revealed he was 4 was unable to walk and bendent for transfers. a wheelchair for mobility and d 11/1/23 written by Nurse		monitor its performance to mak the deficient practice does not The Administrator/Designee wil van transports a week for twelv ensure proper securement of re The Administrator/Designee wil one ride along observation duri transport weekly for twelve wee The Administrator will discuss t results with the IDT during the	reoccur: Il audit 5 ve weeks esident. Il comple ing eks. he audit	s to ete		
	#14 revealed Transport and reported a vehicle transport van and the on the brakes. Residential Emergency Mocontacted. Resident local emergency deposition.	ortation Assistant #1 called the turned in front of the transport aide had to press tent #1 slid out of the geri edical Services were #1 refused to be seen in the transport aide had to press		Quality Assurance Performance Improvement meeting for three The audits will be reviewed to ecompliance is ongoing and will whether there is a need for furt re-education, or modification.	e months. ensure determir	ne		
	report dated 11/1/23 found sitting on the floresident had no compassistance off the floresident #1 was being treatment chair (gering secured properly. The top of three pillows and during transport. Ac	or back into his chair.  ng transported in a dialysis  chair #1) that was not  ne resident was sitting on  nd a mechanical lift pad						

AND PLAN OF CORRECTION IDENTIFICATIO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		<b>345356</b> B. WING				C   <b>2/28/2023</b>	
	NAME OF PROVIDER OR SUPPLIER  RICH SQUARE NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP COL 300 NORTH MAIN STREET RICH SQUARE, NC 27869	•	12/20/2023	
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F 689	this chair was in a relocking device to main the driver applied the forward from the reclaposition which cause from his chair onto the refused to be transported to be transported the EMS crew lifted chair and supplied expective the chair into ensured the resident.  During an interview which was a transported to the resident to ensured the resident to ensured the resident to ensured the resident the facility's transported (geri chair #1) provide (Geri chair #1) provide (Geri chair #1 was a the capability to go in position [a position in shoulder and legs catabove his head]). She secured Resident #1 was tight and the sear reclined. She stated (11/1/23) another drivand she had to come Resident #1 slid undo out of geri chair #1 on seated on his butt. The explained the seat be stay in place when slength to the state of the state of the place when slength the seat be stay in place when slength the seat be st	a reclined position. When clined position there was no intain that position. When a van brakes the chair rocked ined position to an upright d the resident to be ejected to floor. The resident to the floor. The resident to the resident back into the ctra retention straps to a reclined position and was secured with a lap belt.  With Transportation Assistant 30 PM she reported on sporting Resident #1 to a with no other residents in tation van. Transportation Resident #1 was in a chair led by the dialysis center. Clinical care recliner and had not the Trendelenburg which the resident's in the reclined so his legs are not indicated that when she into the van the seat belt at back of geri chair #1 was if that during transportation were pulled out in front of here to an abrupt stop and the seat belt and slipped anto the floor of the van ransportation Assistant #1 ack of geri chair #1 did not the hit the brakes of the van.	F 68	39			

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		<b>345356</b> B. WING			C 12/28/2023		
	NAME OF PROVIDER OR SUPPLIER  RICH SQUARE NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH MAIN STREET RICH SQUARE, NC 27869	•	1 12/20/2020	
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F 689	by EMS staff that the appropriate to use in because it could not further stated the res hospital and requeste appointment. Transp EMS staff assisted in and provided some a secure the chair. Shithe facility no longer geri chair #1 and beg chairs (geri-chair #2) the capability to go in position.  An interview was con 12/19/23 at 1:00 PM accident on 11/1/23. Transportation Assist facility's transportation from under the seat the Resident #1 stated he to the hospital emergine was not injured. Freclined dialysis treat when the incident ocafter the incident ocafter the incident he inchair (geri chair #2). transported to dialysis chair (geri chair #2).  During a phone intermedical Services (EM 1:10 PM he stated he accident on 11/1/23 at accident on 11/1/23 a	e was informed at the scene chair used was not the transportation van be secured in the van. She ident refused to go to the ed to proceed to his doctor's cortation Assistant #1 stated getting him back in the van dditional straps to better e indicated after the incident transported Resident #1 in an to use one of the facility. Geri chair #2 did not have to the Trendelenburg  Iducted with Resident #1 on who stated he recalled the He stated when ant #1 hit the brakes on the n van he suddenly flew out belt to the floor of the van. The refused to be transported ency department because he reported he was in a sament chair (geri chair #1) curred. Resident #1 stated no longer utilized the dialysis ansportation, and was a facility owned geriatric. He stated he was so on 12/19/23 in a geriatric	F 68	39			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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F 689	chair #1). He stated restraint system were chair. EMS Staff #1 system in the van to reclining. EMS Staff assessed and had not Resident #1 was enchospital, but the resident #1 was enchospital, but the resident #1 and the Administration accident. He reported Aide #1 and the Administration wheelchairs were not system of the van.  During an interview with 12/19/23 at 12:22 PM Resident #1 slid out when Transportation on the van because for reported he respondent and recalled that the gerichair #1 transportation in the the incident the facility gerichair (gerichair (geric	dialysis treatment chair (geri the hooks of the van's e fastened on the side of the stated there was no restraint prevent the chair from f #1 stated Resident #1 was o visible injuries. He stated couraged to go to the dent refused. EMS Staff #1 stor came to the scene of the ed he informed Transport compliant with the restraint  with the Administrator on M he reported on 11/1/23 from under the seat belt Assistant #1 hit the brakes she belt was not secure. He ed to the scene of the d being told by EMS Staff #1 should not be used for facility's van. He stated after the began to utilize a facility #2) rather than the dialysis chair #1).  as conducted with a Dialysis esident #1's dialysis center PM. The Dialysis Center at the dialysis center had ment chair (geri chair #1) nonth prior to 11/1/23 with mize the number of transfers	F	689		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER  RICH SQUARE NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 100 NORTH MAIN STREET RICH SQUARE, NC 27869	,	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 689	geri chair (geri chair chair (geri chair (geri chair #1) not have the capabit Trendelenburg positistated the resident I sacrum and Reside discomfort associate lift. She reported the (11/1/23) the facility dialysis in geri chair Nurse stated she with the dialysis treatment to be utilized for training the most out of geri chair #1 was informed that Figure chair. NA #1 stated transported to dialysmonth prior to 11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	ansfer him from the facility's r#2) to the dialysis treatment as the facility's geri chair did lity to be placed in the tion. Dialysis Center Nuse had an open wound on his hat #1 complained about the ed with use of the mechanical hat after the van accident began to send Resident #1 to #2. The Dialysis Center as told by the Administrator hat chair (geri chair #1) could ansportation.  Aurse Aide (NA) #1 was 1/23 at 11:55 AM who reported he call on 11/1/23 at PM from Transportation ated Resident #1 had fallen in the van. She stated she desident #1 slid out of his Resident #1 had been sis for approximately one 23 in a dialysis treatment. She indicated she was ence between a dialysis i chair #1) and the facility's 1/42).	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345356	B. WING _			C <b>2/28/2023</b>	
	ROVIDER OR SUPPLIER  JARE NURSING & REHA			STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH MAIN STREET RICH SQUARE, NC 27869		2/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE CORRECTION OF	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	system in the van to preclining or to preven out if reclined.  During a follow up int on 12/19/23 at 3:00 F aware the manufactu van should not be uswheelchairs. He indictransitioning from gerafter the 11/1/23 incic.  2. Resident #2 was a 11/20/23 for aftercare surgery.  Resident #2's admiss assessment dated 11 cognitively intact. Shwheelchair.	there was no restraint brevent the chair from the resident from slipping the review with the Administrator of the indicated he was rer's instruction stated the ed with chairs other than cated he believed it chair #1 to gerit chair #2 dent was sufficient.  Indicated to the facility on the following joint replacement with the facility on the following joint replacement was easy coded for using a	F6	89			
	revealed a family ment about an incident in the of the investigation results (Transportation Assist policy in reporting the was conducted by nut the Administrator. The properly report an incepolicy." The Administration complete.  Review of progress in						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION SUILDING		(X3) DATE SURVEY COMPLETED	
		345356	B. WING			C 12/28/2023	
	ROVIDER OR SUPPLIER  JARE NURSING & REHA	AB		STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH MAIN STREET RICH SQUARE, NC 27869	•	12/20/2023	
(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)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	Assistant #1 on 12/19 reported she was train Resident #4 on 11/27 pulled out in front of habrupt stop. Transposhe may have not but belt. She stated the her wheelchair onto the buttocks. Transports assisted Resident #2 buckled the seat belt resident's) doctor's all she contacted Nurse to not report it to admiresidents didn't mention Assistant #1 stated the was fine and did not but had slid out of her whole did not tell Transport Assistant #1 had slid out of her whole did not tell Transport to the Administrator to was already aware. State the resident at the doinformed them, and the Administrator.  A progress note by the 11/28/23 revealed Resident #1.	view with Transportation 2/23 at 12:30 PM she asporting Resident #2 and 2/23. She reported someone are and she came to an ortation Assistant #1 stated ackled Resident #2's seat resident slid forward out of the floor of the van onto her ation Assistant #1 stated she back into her wheelchair, and continued to her (the appointment. She reported Aide #1 who instructed her ainistrative staff if the on it. Transportation are resident indicated she have any pain.  ducted with Nurse Aide #1 at 11:55 AM who reported are call on 11/27/23 from 1 who stated Resident #2 seelchair. She stated she ation Assistant #1 not to She indicated she did went are port the incident but he she explained the family met actor's office, the resident then the family notified the desident #2's family member	F 6				
	x-ray was done, and fracture, separation a	rns about shoulder pain. An the results were negative for and dislocation.					

I ? · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · · · · · · · · · · · · · · · · ·		, ,	(X3) DATE SURVEY COMPLETED	
		345356	B. WING_		1	C 2/28/2023	
	ROVIDER OR SUPPLIER  JARE NURSING & REHA	I		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869		212012023	
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F 689	Continued From page		F 6	89			
	Nursing on 12/19/23 was made aware of F family member on 11 Medical Director.  A phone interview wa #2 on 12/19/23 at 10: 11/28/23 Transportation the brakes of the vanother resident's whreported the wheelch but her seat belt secuwas not buckled. R Transportation Assist her chair, buckled he doctor's appointment advised her family of the doctor's office. S complained of should not recall falling on henew and she thought van. Resident #2 ind not necessary. She sfew days later. Resid done and they did not During an interview wappeared alert to per situation, on 12/19/23 did not recall any inci out of their wheelchail She added she did not transportation. Review of the investiges.	ant #1 assisted her back into r in and they went to her. Resident #2 reported she the incident when she got to he stated the next day she ler pain. She stated she did er shoulder but the pain was it was from the fall in the licated pain medication was stated the pain resolved a ent #2 stated x-rays were t find anything.					

AND BLAN OF CORRECTION IDENTIFICATION NUMBER		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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F 689	properly secure the the facility according terminated from emp was completed by the An interview was condaministrator on 12/1 stated he was made from her wheelchair from Resident #2's find He stated the incide Transportation Assist employment for not failing to properly secondary of the imm. The facility provided jeopardy removal planta planta from the imm. The facility provided jeopardy removal planta from the imm. The facility provided jeopardy removal planta from the imm. The facility provided jeopardy removal planta from the imm. The facility provided jeopardy removal planta from the facility those recipies are likely to suffer, as a result of the noncondamination. When transporting Fappointments outside Assistant (TA) #1 fair wheelchairs in the facility and as a causing Resident #1 which was not a start the van's floor. On transported to a document in the facility of the form of the facility of the facility and the facility of the facility	tion Assistant #1 failed to resident and did not contact to policy. She was ployment. The investigation he Administrator.  Inducted with the 19/23 at 12:22 PM who aware of Resident #2 fell when the concern came in amily member on 11/27/23. In the was investigated and tant #1 was terminated from reporting the incident and cure the resident.  PM, the Administrator was rediate jeopardy.  The following immediate an with a removal date of serious adverse outcome as impliance.  Residents #1 and #2 to redee the facility, Transportation led to safely secure their recility transportation vehicle. Poplied the brakes on the par came out in front of it, to slide out of his geri-chair modard wheelchair and onto 11/27/2023, while being tor's visit, Resident #2 fell out to the van's floor. Resident	F 6	89		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED C	
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F 689	Continued From pa	nge 28	F 6	39		
	Residents #1 and # affected by the defi	#2 were identified to be cient practice.				
		re transported in the facility to potentially be affected by ce.				
	process or system adverse outcome fi when the action will On 11/27/23 TA #1 investigation for vic was terminated on The current transport	was suspended pending plating the safety policy. She				
	and securement of in the facility transp demonstration obse Director. The facilit place of geri-chairs or use a medical tra	/21/23 regarding the safety all residents being transported portation van, with a return erved by the Maintenance by will utilize wheelchairs in when transporting residents ansportation company when portation aide will be				
	responsible for ens to a proper chair pr van. The transporta ensuring residents chairs for transport	uring residents are transferred ior to transporting in the facility ation aide was educated on are transferred to proper ation and that geri-chairs are n 12/21/2023 by the				
	safety training upor will be conducted be and will include a re competency. This t	B all transport aides will receive in hire and annually. Training by the Maintenance Director eturn demonstration of raining will involve a review of policy, an in-service regarding				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  JARE NURSING & REHA	L		STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH MAIN STREET RICH SQUARE, NC 27869		2/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From page	e 29	F 6	89			
	transported in the fac supervision as neede						
	Onsite validation of the removal plan was confinterviews verified on Assistant #1 was sus investigation, and she Inservice records and Transportation Assist policy on transportation-service regarding the all residents being trateransportation van, whoserved by the Mair addition, Nurse Aider if needed for Transportation Director. An observation Director. An observation assistant #2 secured a wheeled manufacturer's instructional Assistant #2 reported ensuring residents and chairs for transportation proper chairs, and the ensuring residents we chairs in accordance instructions prior to the Maintenance Director safety training with vehire and annually for	in 1/27/23 Transportation pended pending was terminated on 12/4/23. Interview confirmed ant #2 reviewed the facility's on and completed an he safety and securement of insported in the facility tha return demonstration attenance Director. In #1 who was a backup driver retation Assistant #2, lucation and performed a for the Maintenance tion verified the current int (Transportation Assistant					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345356	B. WING _			C <b>12/28/2023</b>
	ROVIDER OR SUPPLIER  JARE NURSING & REH	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	12/20/2025	
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F 726 F 726 SS=K	the appropriate comprovide nursing and resident safety and a practicable physical, well-being of each reresident assessment and considering the diagnoses of the factor accordance with the at §483.70(e).  §483.35(a)(3) The fallicensed nurses have and skill sets necessing assessments, and designed for the same and skill sets necessing assessments, and designed for the same and skill sets necessing assessments, and designed for the same and skill sets necessing assessments, and designed for the same and skill sets necessing assessments, and designed for the same and skill sets necessing assessments.	Staff ()(4)(c)  vices e sufficient nursing staff with betencies and skills sets to related services to assure attain or maintain the highest mental, and psychosocial esident, as determined by its and individual plans of care number, acuity and dility's resident population in facility assessment required  actility must ensure that the specific competencies eary to care for residents'	F 7	26		1/26/24
	to demonstrate complete the complete co	ure that nurse aides are able betency in skills and y to care for residents'		F 726 1. How corrective action will be accomplished for resident(s) four have been affected.		

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID IVC	<i>J.</i> 0930 <del>-</del> 0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345356	B. WING _			12/	/28/2023
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	·	
DICH SOI	JARE NURSING & REHA	A D		300	NORTH MAIN STREET		
KICH SQ	DARE NURSING & REH	AB		RIG	CH SQUARE, NC 27869		
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F 726	Continued From pag	0.21	F 7	200			
F 720	-		F 7	26	D : 1		
		acility Nurse Aide, was			Residents #1 and #2 were identified to	•	
	· ·	was aware of the facility's			have been affected.  TA #1 was terminated on12/04/23 for		
	for safe securement	manufacturer's instructions			violating the safety policy.		
		ining. Nurse Aide #1 was			2. All Residents who are transported	lin	
	•	porting a resident in a			the facility van were identified to		
		ded chair with a wheeled			potentially be affected by the deficient		
	based) was not in ac				practice.		
	transportation van's ı	manufacturer's instructions.			3. What measure will be put in place	or	
	In addition, the facilit	y failed to verify			systemic changes made to ensure that		
	· ·	tant #1's competency to			the identified issue does not occur in the	ie	
		ty during transportation for 1			future?		
		orted residents in the facility's			The current transportation aide has		
	-	On 11/1/23 Transportation			reviewed the facility's policy on		
		a geriatric wheelchair (geri			transportation and completed an		
	, ,	esident #1 and during sident slid out of the chair			in-service on 12/21/23 regarding the safety and securement of all residents		
		van. Resident #1 was not			being transported in the facility		
		3 Transportation Assistant #1			transportation van, with a return		
		ent #2's seatbelt and during			demonstration observed by the		
	transportation the res	•			Maintenance Director.		
		the floor of the van. Resident			The facility will utilize wheelchairs in pla	ace	
	#2 reported pain in h	er right shoulder the			of geri-chairs when transporting reside		
	following day. This d	eficient practice had a high			or use a medical transportation compa	ny	
	_	g in serious harm, injury, or			when needed.		
		ho were transported in the			. The transportation aide was educated	on	
	facility's transportation	on van.			ensuring residents are transferred to		
		44/4/00			proper chairs for transportation and that	ıt	
		began on 11/1/23 when			geri-chairs are not proper chairs on	or	
	· ·	tant #1 failed to demonstrate ne transported Resident #1 in			12/21/2023 by the Maintenance Director Beginning 12/21/23 all transport aides		
		was not in accordance with			receive safety training upon hire and	v v 111	
	_	nstructions and the resident			annually. The training will be conducted	d bv	
		The immediate jeopardy was			the Maintenance Director and will inclu	-	
		3 when the facility provided			a return demonstration of competency.		
		ole allegation of compliance.			This training will involve a review of the		
		out of compliance at a lower			transportation policy, an in-service		[
		f E (no actual harm with			regarding the safety and security of		
	potential for more that	an minimal harm that is not			residents being transported in the facili	ty	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
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TVAIVIL OF T	TO VIDER OR GOLT EIER				· <b>L</b>	
RICH SQL	JARE NURSING & REHA	B		300 NORTH MAIN STREET		
				RICH SQUARE, NC 27869		
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F 726	Continued From page	÷ 32	F 72	26		
	immediate jeopardy) ensure monitoring systeffective related to surple accidents.  The findings included This tag is cross-reference. F689: Based on obsetinterviews with reside nurse, and Emergence facility failed to provide facility's transportation wheelchairs were utility accordance with man of 4 residents reviews #1 and Resident #2).	to complete education and stems put into place are pervision to prevent:		transportation van, and super needed.  4. Indicate how the facility monitor its performance to mathe deficient practice does not The Administrator/Designee was residents weekly to ensure reproper wheelchair and is proposecured.  The Administrator will discuss results with the IDT during the Quality Assurance Performan Improvement meeting for three The audits will be reviewed to compliance is ongoing and was whether there is a need for fure-education, or modification.	plans to ake sure that of reoccur will audit 5 esident is in perly as the audit e monthly nce ee months. o ensure ill determine urther audits,	
	chair with a wheeled #1 and during transport of the chair onto the f was not injured. On Assistant #1 did not be and during transportatine wheelchair and or Resident #2 reported the following day. The likelihood of serious has review of a form date "Transportation Aide Responsibilities Cheemajor duties was "ope van in a safe manner to operating." This for Transportation Assists	base) to transport Resident ortation the resident slid out cloor of the van. Resident #1 11/27/23 Transportation buckle Resident #2's seatbelt stion the resident fell out of anto the floor of the van. pain in her right shoulder ease incidents had the high earm, injury or death.  Ded 9/8/23 entitled Major Duties and eklist" revealed one of the erating the facility's transport and securing residents prior further indicated ant #1 had completed rated competence in all				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  JARE NURSING & REH	АВ		STREET ADDRESS, CITY, STATE, ZIP C 300 NORTH MAIN STREET RICH SQUARE, NC 27869	ODE	12/20/2020
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F 726	Continued From pag	ge 33	F	726		
	12/19/23 at 11:55 Al Transportation Assis lift and restraint syst transportation van p Assistant #1 providir She explained she h 12 years and had dr to becoming a medic explained that the for quit suddenly. She Assistant #1 was an was asked to move transportation driver Maintenance Director these changes. She (NA #1) was most fatrained Transportation she had Transportation to operate the I	rior to Transportation ng transportation to residents. nad worked for the facility for iven the van in the past prior cation aide. NA #1 further irmer transportation assistant indicated Transportation NA at the facility and she				
	dated 11/1/23 revea informed the Emerg when they arrived th aide] and did not knot this transport van wo	ency Medical Services report led Transportation Aide #1 ency Medical Services staff at "she was just a [nurse bw how anything about how brks, indicating that she has er training for the job that she				
	Services staff #1 (El PM he stated he rep accident on 11/1/23 #1 was being transp	with Emergency Medical MS #1) on 12/19/23 at 1:10 orted to the scene of the and observed that Resident orted in a geri chair (geri Transportation Aide #1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345356	B. WING _				28/2023
	ROVIDER OR SUPPLIER  JARE NURSING & REHA	AB		STREET ADDRESS, CITY, STATE, ZIP COE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	ÞΕ	•	
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F 726	During an interview with 11:55 AM she revealed transporting a resider accordance with the imanufacturer's instruction. An interview was con Assistant #1 on 12/19 indicated she was an role at the facility price. She explained that the assistant quit sudden provide transportation #1 stated Nurse Aide secure a wheelchair She indicated that was She reported she beg for the facility on 9/8/ unaware geri chair #1 for transportation van un Emergency Services fell from geri chair #1 was acceptable to us reported her retrainin reading the policy an policy did not mention Assistant #1 stated s #2's seat belt on 11/2 falling out of her wheel An interview was contact the same acceptance of th	e had not been trained or cility's transportation van.  with NA #1 on 12/19/23 at ed she had not known that in a geri chair was not in facility's transportation van's ctions.  ducted with Transportation van's ctions.  ducted with Transportation NA and had worked in that or to providing transportation ly and she was asked to in. Transportation Assistant #1 showed her how to on the transportation van. as the extent of her training. It was not allowed to be used ents in the facility's till she was told by staff #1 after Resident #1. She stated she thought it is geri chair #2. She g on 11/3/23 consisted of d initialing each page. The in geri chairs. Transportation he forgot to secure Resident 127/23 which resulted in her elichair on 11/27/23.	F 7	26			
	he supervised the tra when Transportation	at 11:40 AM. He indicated nsportation staff. He stated Assistant #1 began work in was out of the office and she					

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F 726	explained NA #1 was his absence because prior to becoming a The Maintenance E on leave on 11/1/23 his geri chair in the He wasn't involved not involved with re Assistant #1. He st facility used to train verbal instruction was A form entitled "Residated 11/3/23 revea #1's initials on each signature. The form Transportation Aide re-training on the famanufacturer's instruction or if her competence 12/19/23 at 3:00 PM Assistant #1 was that transporting resider retrained Transport after the van incide of his wheelchair. The view of the facility Assistant signed. Of competencies by The Administrator reinformed by EMS is supposed to be use had not realized this explained that he the specific to geri chail	#1. The Maintenance Director as responsible for training in se she provided transportation medication aide in the facility. Director reported that he was shen Resident #1 fell out of facility's transportation van. with any investigation and was straining Transportation tated the only strategy the stransportation assistants was with hands-on demonstration.  Isident Transportation Policy" aled Transportation Assistant in page with her dated in provided no indication if shell was provided with acility's transportation van's ructions for safe securement	F 72	26			

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		345356	B. WING			C 2/28/2023	
	ROVIDER OR SUPPLIER  JARE NURSING & REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869		12/26/2023	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 726	to be used for transp facility's transportation stated that after the 2 11/27/23, where Ress wheelchair because Transportation Assist On 12/19/23 at 4:15 Administrator was intigeopardy. The facility provided action plan with a collidentify those recipies are likely to suffer, a a result of the noncolliwhen transporting Rappointments outside Assistant (TA) #1 fail wheelchairs in the fa On 11/1/23, TA #1 aptransport van as a cacausing Resident #1 which was not a stanthe van's floor. On 1 transported to a doct of her wheelchair ontig #2 seatbelt was not facility failed to ensure	her that geri chairs were not orting residents in the on van. The Administrator 2nd van incident occurred on ident #2 fell out of her she was not secured, tant #1 was terminated.  PM, the facility's formed of the immediate  the following corrective mpletion date of 12/22/23. Into who have suffered, or serious adverse outcome as impliance.  esidents #1 and #2 to be the facility, Transportation and to safely secure their cility transportation vehicle. In order the brakes on the fact came out in front of it, to slide out of his geri-chair and wheelchair and onto 1/27/2023, while being the safely secure their cility transportation vehicle. The safely secure their cility transportation vehicle. The safely secure their came out in front of it, to slide out of his geri-chair and onto 1/27/2023, while being the safely secure the safely wheelchair and onto 1/27/2023, while being the safely safely train to the van's floor. Resident fastened by TA #1. The re TA #1 was properly train in sportation safety prior to	F 7:	26			
	affected by the defici	were identified to be ent practice.  transported in the facility					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	, ,	ATE SURVEY DMPLETED	
		345356	B. WING			C <b>12/28/2023</b>
	ROVIDER OR SUPPLIER  JARE NURSING & REH	HAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869		'	12/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 726	Continued From pa van were identified the deficient practic	to potentially be affected by	F 72	6		
	process or system f adverse outcome fr when the action will On 11/27/23 TA #1	was suspended pending lating the safety policy. She				
	facility's policy on tr an in-service on 12/ and securement of in the facility transp demonstration obse Director. The facility place of geri-chairs or use a medical tra needed. The transp responsible for ensi- to a proper chair pri- van. The transportal ensuring residents a	uring residents are transferred or to transporting in the facility tion aide was educated on are transferred to proper ation and that geri-chairs are in 12/21/2023 by the				
	safety training upon training will be cond Director and will ind competency. This tr the transportation p the safety and secu	all transport aides will receive hire and annually. The lucted by the Maintenance lude a return demonstration of raining will involve a review of olicy, an in-service regarding rity of residents being acility transportation van, and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345356	B. WING			
	ROVIDER OR SUPPLIER  JARE NURSING & REHA		STREET ADDRESS, CITY, STATE, ZIP CODE  300 NORTH MAIN STREET  RICH SQUARE, NC 27869		12/28/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
F 726	Continued From page supervision as neede		F 72	6		
	Onsite validation of the removal plan was confinterviews verified on suspended pending in terminated on 12/4/23 transportation aide, To interview confirmed To policy on transportation in-service regarding that residents being transportation van, with observed by the Main observation verified the assistant secured a with manufacturer's instruction was educated on ensignation of the proper that geri-chairs are not she is responsible for	11/27/23 TA #1 was nevestigation, and she was B. The facility has 1 current A #2. Inservice records and A #2 reviewed the facility's on and completed an he safety and securement of insported in the facility th a return demonstration tenance Director. An he current transportation wheelchair according to octions. TA #2 reported she				
F 755 SS=K	stated he is responsite verification of compete for any transportation jeopardy removal date. Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b): §483.45 Pharmacy Some facility must providings and biologicals them under an agree.	at. The Maintenance Director ble for safety training with ency on hire and annually aide. The immediate e of 12/22/23 was validated. edures/Pharmacist/Records (1)-(3)  ervices ide routine and emergency to its residents, or obtain	F 75	5		1/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345356	B. WING		C	
	ROVIDER OR SUPPLIER  JARE NURSING & REH		STREET ADDRESS, CITY, STATE, ZIP CODE  300 NORTH MAIN STREET  RICH SQUARE, NC 27869		12/28/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 755	permits, but only und a licensed nurse.  §483.45(a) Procedul pharmaceutical serv that assure the accurdispensing, and adminicologicals) to meet service (must employ or obtain pharmacist whoseless of the provision that facility.  §483.45(b)(1) Provide aspects of the provision facility.  §483.45(b)(2) Estably receipt and disposition sufficient detail to entereconciliation; and service facility.  §483.45(b)(3) Determined and permits reconciliation and that an acting maintained and permits reconciliation a	ster drugs if State law der the general supervision of res. A facility must provide dees (including procedures rate acquiring, receiving, dinistering of all drugs and deen needs of each resident.  Consultation. The facility in the services of a licensed des consultation on all dies consultation on all dies consultation of pharmacy services in dishes a system of records of on of all controlled drugs in able an accurate	F 75	F 755  1. How corrective action will be accomplished for resident(s) found to have been affected Resident # 3 s Vimpat was ordered on 12/04 and received from pharmacy on 12/06.  2. Identify other residents who have potential to be affected All other residents' medication orders were reviewed on 12/21/23 to ensure a	the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BOILDII			C	
		345356	B. WING		C		
NAME OF D	ROVIDER OR SUPPLIER	040000	1	STREET ADDRESS, CITY, STATE, ZIP COI		/28/2023	
NAME OF T	NOVIDEN ON SOIT LIEN				JL		
RICH SQI	UARE NURSING & RI	EHAB		300 NORTH MAIN STREET			
				RICH SQUARE, NC 27869			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 755	Continued From p	age 40	F 7	755			
F 755	incidents of seizur 12/5/23. Following physician ordered medication comme medication for seizinjection and the faccess the emerg was contacted and to the Emergency administered. The activity after received discharged back to Upon return from administered Vimp 12/6/23 as the meobtained from the practice was for 1 pharmaceutical seizures. The immon 12/22/23 when acceptable credibly jeopardy removal. compliance at a loa E (no actual harminimal harm that ensure completion	the activity between 12/4/23 and the fourth seizure (12/5/23) the Ativan (an antianxiety only used as a rescue zures) via intramuscular (IM) acility staff were unable to ency medication supply. EMS d the resident was transported Room (ER) where Vimpat was resident had no further seizure ving Vimpat and was the ER the resident was not beat until the evening dose on dication had still not been pharmacy. This deficient of 3 residents reviewed for	F7	medications were available. who had a medication with leweek's supply available were This action was completed by and MDS nurse.  3. What measure will be posystemic changes made to enthe identified issue does not future?  All licensed nurses, including were educated by the DON of medication from the emerger dispensing system per facility procedure on 12/21/23 no nupermitted to work the medication completing education.  Newly hired licensed nurses, agency staff, will be educate accessing medications from emergency dispensing system policy and procedure, according orientation by Human Resource beginning 12/21/23. The nurse or medication aided administering medications we education beginning 12/21/2 DON and pharmacy consultations obseless than a week supply available.  The DON obtained charge not supply available to the process of the poly obtained charge not supply available.	ess than a e reordered. by the DON  ut in place or insure that occur in the g agency staff, on accessing incy by policy and irrse will be ention cart prior  including d on the im per facility lingly in irces Director  elill receive 3 from the int on irved to have lable via the  urse access		
	The findings include			from the pharmacy to the em medication system on 12/20/ charge nurse access allows	ergency 23. The		
	3/2/23 and readmi with diagnoses wh hemorrhage, seizu	nitially admitted to the facility on itted to the facility on 11/13/23 nich included traumatic subdural ure disorder/epilepsy, traumatic astrostomy status (a tube		grant access to nurses worki facility.  The pharmacy will provide acmonthly in-service education 12/21/23 for the nurses and	ng at the dditional beginning		

Facility ID: 923433

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	OATE SURVEY OMPLETED
		345356	B. WING			C <b>12/28/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			12/20/2020
DIOL OO	LARE NURSING & RELLA	. n		300 NORTH MAIN STREET		
RICH SQ	JARE NURSING & REHA	AB		RICH SQUARE, NC 27869		
(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 ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 755	Continued From page	e 41	F 75	55		
	surgically placed into			aides regarding medication		
	J 7 1	,		administration, ordering, acco	essing	
		Resident #3 dated 9/25/23		emergency supply and all oth	ner services	
		d (anticonvulsant) oral		available.		
	_	iters (ml) via G-tube three		4. Indicate how the facility	•	
	times a day related to	o epilepsy.		monitor its performance to m		
	Λ physician order for	Resident #3 dated 10/15/23		the deficient practice does not The Director of Nursing/Design		
		solution 10/milligrams		audit 5 residents meds daily		
	(mg)/ml give 25 ml via G-tube two times a day for			5 days a week for 12 weeks.		
	, , ,	g/25ml two times a day.		The Administrator will discus		
		,		results with the IDT during th	e monthly	
	_	ant change Minimum Data		Quality Assurance Performar		
		lentified the resident as		Improvement meeting for three		
		npaired cognition. The MDS		The audits will be reviewed to		
	coded the resident as	s naving seizure I for gastrostomy (G-tube)		compliance is ongoing and w whether there is a need for fu		
	status.	nor gastrostorily (G-tube)		re-education, or modification		
	status.			re-education, or modification	•	
	Resident #3's physici	an order summary for				
		cated the orders for valproic				
	acid and Vimpat rema	ained as active orders.				
	The Medication Admi	nistration Record (MAR) and				
		lled the following information				
	for Resident #3:					
	- 11/25/23: The MAR	indicated no doses of				
	Vimpat were adminis	tered and a nurse's note				
		evealed Vimpat was on				
	order.					
		indicated no doses of				
		tered and a nurse's note				
	written by Nurse #6 r order.	evealed Vimpat was on				
		indicated no doses of				
		tered and a nurse's note				
		evealed Vimpat was out of				
	_	ion had been signed by the				

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  300 NORTH MAIN STREET  310 NORTH MAIN STREET	C 2/28/2023
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  300 NORTH MAIN STREET  300 NORTH MAIN STREET	1/20/2023
RICH SQUARE, NC 27869	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
provider 11/28/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #2 stated, "Waiting on pharmacy." - 11/29/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #2 stated, "Coming from pharmacy." - 11/30/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #2 stated, "Coming from pharmacy." - 11/30/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #8 revealed the medication was not available 12/1/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #3 indicated the medication was not available 12/2/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #5 indicated the medication was not available 12/3/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #5 indicated the medication was not available 12/4/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #5 indicated the medication was not available 12/2/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #2 stated, "On order." - 12/5/23: The MAR indicated the morning dose of Vimpat was not administered and a nurse's note written by Nurse #3 stated, "Out of stock. [Director of Nursing] and provider notified."  An interview was conducted on 12/20/23 at 10:12 am with staff Nurse #4 who stated she gave Resident #3 his last dose of Vimpat on 3rd shift	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345356	B. WING		C <b>12/28/2023</b>	
	ROVIDER OR SUPPLIER  JARE NURSING & REH	AB	3	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH MAIN STREET LICH SQUARE, NC 27869	1 12/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 755	Continued From pag to the physician befo	re 43 ore the medication ran out.	F 755			
	copies of the Vimpat to the pharmacy. As	pm the DON stated she had prescriptions that were sent of the survey exit date on tion had not been provided.				
	at 4:47 pm with ager Resident #3 ran out 11/25/23, she called request a reorder on revealed 11/26/23 w and she was not awa not available. When for ordering refills of reported for a contro Vimpat, the nurse or call or fax the physic	w was conducted on 12/20/23 ncy Nurse #6. She stated that of his prescription on and faxed the physician to Resident #3's Vimpat. She as the last day she worked, are Resident #3's Vimpat was asked what the process was medication Nurse #6 illed substance such as in the medication cart, would ican before the medication ran oftion reorder and he sent it to				
	pm with agency Nursadministered the me 11/29/23, and 12/4/2 was a controlled subsasigned prescription the medication was pharmacy and was tooming on 11/29/23. called the pharmacy medication was on it stated when the seizarrived on 12/04/23	nducted on 12/19/23 at 2:30 se #2 who had not dication on 11/28/23, 13. Nurse #2 indicated Vimpat estance, and they would need in to reorder. She stated when not available, she called the old the medication was She indicated when she 11/29/23, she was told the sway. Agency Nurse #2 ture medication had not when she returned to work ent DON and gave her a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		345356	B. WING_			C <b>12/28/2023</b>	
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  300 NORTH MAIN STREET  RICH SQUARE, NC 27869		12/26/2023	
(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 ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	about the process for medication Nurse #2 building the doctor we and staff faxed it to the physician was not in the needed a refill of a medication to the phit to the pharmacy.  An interview was consponding with agency Nursedocumented the Vimperson and their procedure was the pharmacy. She indicated she called and physician on 12/3/23 medication. She indicated the pharmacy is indicated she did recontacted the pharmacy is physician for a signed the medication cart, we physician for a signed send it to the pharmacy is note written 12/04/23 at 2:30 pm responsible to the pharmacy is note written 12/04/23 at 2:30 pm responsible to the pharmacy is note written 12/04/23 at 2:30 pm responsible to the pharmacy is note written 12/04/23 at 2:30 pm responsible to the pharmacy is note written 12/04/23 at 2:30 pm responsible to the pharmacy is note written 12/04/23 at 2:30 pm responsible to the pharmacy is note written 12/04/23 at 2:30 pm responsible to the pharmacy is note written 12/04/23 at 2:30 pm responsible to the pharmacy is note written 12/04/23 at 2:30 pm responsible to the pharmacy is not the pharmacy is not the pharmacy in the pharmacy in the pharmacy is not the pharmacy in the pharmacy is not the pharmacy in the pharmacy in the pharmacy is not the pharmacy in the pharmacy is not	the physician. When asked ordering refills of revealed when in the build sign the prescription he pharmacy. When the the building the nurse edication that was a the nurse would fax a refill ysician to sign and he faxed ducted on 12/20/23 at 2:42 e #3 who on 12/01/23 but as not available. Nurse ded a signed prescription or call the physician for a he sent the order to the ated she could not called the pharmacy to see s.  If was conducted on 12/20/23 but a message for the to order the seizure but at a message for the to order the seizure but at a message. Nurse mot remember if she are to find the Vimpat. Nurse mot remember if she are to find the Vimpat. Nurse mot remember if she are to find the Vimpat. Nurse mot remember if she are to find the Vimpat. Nurse mot remember if she are to find the Vimpat. Nurse mot remember if she are to find the Vimpat. Nurse mot remember if she are to find the Vimpat. Nurse mot remember if she are to find the Vimpat. Nurse mot remember if she are to find the vimpat. Nurse mot all or fax the diprescription, and he would be diprescription, and he would be diprescription, and he would cy.	F 7	55			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345356	B. WING		C 12/28/2023	
	ROVIDER OR SUPPLIER	HAB	3	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NORTH MAIN STREET RICH SQUARE, NC 27869	12/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 755	she arrived at his roshowing seizure actiquestions like he we stated Nurse #2 and resident was completed normal. Resident #4 hadn't shown anym.  An interview was considered at 12/19/23 at 11:33 and #3 on 12/04/23. She Resident #3 was has she arrived to his roseizure activity. Nurseident #3 and comake sure he was and 12/04/23.  A nurses' notes writh 12/05/23 at 10:14 and shaved Resident and the resident for approximately 2. The note indicated again at 10:10 am with a nurse's note writh on 12/05/23 his arm body for 10 seconds she reported the indicated the indicated she reported she	com the resident was not be tivity but wasn't answering could normally do. The note of staff stayed by his side until etely alert and responding like 3 was in stable condition and core seizure activity as of yet.  Inducted with Nurse #2 on my who worked with Resident estated staff reported awing seizure activity and when com, she did not observe rese #2 stated she stayed with intinued to monitor him, to alert and at his baseline on  Item by Nurse #1 dated my revealed an aide bathed in the state activity was displayed seizure like activity minutes or less in duration. Seizure activity was displayed while working with therapy.  Inducted with Rehabilitation at while bathing Resident #3 as drew tight up against his is then ended. She indicated cident to the nurse (Nurse #1) aff.  In the py Nurse #1 dated 12/5/23 are sident sent out to hospital ity. The note indicated episodes of seizure activity	F 755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		DATE SURVEY COMPLETED		
		345356	B. WING _			C <b>12/28/2023</b>	
	ROVIDER OR SUPPLIER  JARE NURSING & REH	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869		12/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 755	Continued From pag	ge 46	F 7	755			
	PM with Nurse #1. N 11/27/23 she texted prescription request physician to sign an refill. Nurse #1 state on Tuesday 12/05/2 medication cart. She been in earlier doing Resident #3 had pre and told staff to adm Nurse #1 indicated to found no Vimpat was the emergency medication of the staff, including the Ativan. She state she observed Resid became stiff, he got said he was okay. N no Vimpat available emergency medication to of the staff of the s	nducted on 12/19/23 at 12:02 Nurse #1 stated on Friday Resident #3's physician a ing the Vimpat, for the d fax over to the pharmacy for d when she returned to work 3, the Vimpat was not on the e reported the physician had g rounds and was aware evious seizure activity that day ninister the Vimpat or Ativan. The DON began to search and is in the facility. She indicated ication supply was stored in a lispensing machine and none g the DON, had access to pull ed on 12/05/23 at 1:47 PM, ent #3's contracted arm still, for a minute and then he lurse #1 stated as there was , staff could not access the ion supply for Ativan, she physician said to send the ER.					
	Director dated 12/05 had recurrent seizur known history of sei was noted to recove episodes. He was a epilepticus (a recurr recovery between sucurrently on valproid Medical Director ind he made the decision the local emergency	mpleted by the Medical 5/23 revealed Resident #3 re activity on 12/05/23 with zure disorder. The resident er in between the seizure t high risk for status ent seizure activity without eizures) impending. He was e acid plus Vimpat. The icated due to clinical condition on to transfer Resident #3 to or department for further econdary to recurrent seizures					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	E CONSTRUCTION	, ,	TE SURVEY MPLETED		
		345356	B. WING		C 12/28/2023		
	NAME OF PROVIDER OR SUPPLIER  RICH SQUARE NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  300 NORTH MAIN STREET  RICH SQUARE, NC 27869		12/20/2023	
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 755	he could not recall the by staff that Resident stated that due to the to give the resident I facility staff could no he sent Resident #3 He stated he could revailability of Resident The EMS Report dated dispatch received the arrived at the facility informed EMS Resident hospital per physically not having the (Vimpat). When asked seizures the nurse in seizures on this dated 8:18 AM, 10:10 AM at the facility at 3:25 Plated 3:56 PM. No seizurent resident #3 we seizure.	r was interviewed on and 2:16 PM. He indicated he exact date, but he was told at #3 had seizure activity. He exercises activity he wanted M Ativan. He stated the transfer get ahold of the Ativan so out to the ER for evaluation. Not comment on the ent #3's Vimpat.  Ited 12/05/23 indicated he call at 2:50 PM and they at 2:57 PM. The nurse lent #3 was being sent out to sician request due to the exercisent's medication had about the resident having andicated Resident #3 had 3 he (12/5/23) at these times: and 1:47 PM. EMS departed M and arrived at the hospital are activity was noted during and report to the hospital are so noted to start having a	F 75	5			
	Resident #3 present history of seizures, hate and had been of (11/24/23). He was responsive but confuindicated he was tresodium chloride 0.9	dated 12/05/23 revealed ed on 12/05/23 for prior had three seizures on this but of Vimpat since Friday hoted as alert, verbally used. The hospital report hated with Vimpat 200 mg in hopercent 50 mL via IV					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345356	B. WING			C <b>12/28/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	·	12/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 755	noted. The record reports medication the pharmacy empl [Resident #3] gettir prescribed" Resilisted as seizures, sononcompliance with A nurse's note date revealed the residenew orders.  A nurse's note date by Nurse #1 indicated administered for the out of stock.  An interview was concept American and She revealed the pharmacy administration and She revealed the pharmacy told it was found be stated the medication was not called the pharmacy told it was found be stated the medication received his first do the evening. The Dhad not gone to the #3's Vimpat. The Dhave had his medication to the pharmacy driver could not find medication to the pharmacy could not find medication to the pharmacy to the pharmacy driver had driver could not find medication to the pharmacy to the pharmacy driver to the pharmacy driver had driver could not find medication to the pharmacy to the pharmacy driver had driver could not find medication to the pharmacy to the pharmacy driver to the pharmacy driver had driver could not find medication to the pharmacy to the pharmacy driver had driver could not find medication to the pharmacy to the pharmacy driver had driver could not find medication to the pharmacy the pharmacy driver had driver could not find medication to the pharmacy the pharmacy driver had driver could not find medication to the pharmacy the pharma	stated, "Spoke with facility, has not been picked up from hasized importance of ag his medications as ident #3's diagnoses were seizure disorder, and a medication regimen.  2d 12/05/23 at 9:52 pm ent returned from ER with no enterturned from ER with no e	F 7	55		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345356	B. WING_			C <b>12/28/2023</b>
	ROVIDER OR SUPPLIER  JARE NURSING & REH			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	<u> </u>	12/20/2023
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 755	ordered IM Ativan or facility had access to supply and could no revealed the facility in October, gotten a supply system from not received training. The DON indicated revealed prior to the administered at the last received the me 11/24/23.  A phone interview w 1:20 pm with the facilidicated Resident # Vimpat ran out on 11 was sent to the ER Pharmacist stated the Vimpat for 10 days I potential for seizure attempted delivery to and could not deliver attempted delivery to and could not deliver the facility and returned.  An interview was copm with the Administ of the issue with the Vimpat they were in pharmacy, the DON pharmacy, and were The Administrator renotify the facility phase of medication and resign the prescription stated he was not at the supplementary and were stated the was not at the supplementary and were the pharmacy and th	ge 49  ed when the physician in 12/05/23, no staff in the of the emergency medication it access the Ativan. The DON shad changed their pharmacy in emergency medication the pharmacy and staff had in on its use or had access. Resident #3's medical record evening dose of Vimpat facility on 12/06/23, he had edication at the facility on as conducted on 12/28/23 at editity Pharmacist #1. She fa's MAR documented the facility Pharmacist #1. She fa's sizure activity. The fact abruptly stopping the resident #3 would have the facility stopping the resident #3 would have the fact abruptly stopping the fact abruptly stop	F 75	55		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345356	B. WING _		,	C 12/28/2023
	ROVIDER OR SUPPLIER  JARE NURSING & REH	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	'	.=======
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 755	management the me The Administrator in arrive, staff should of the status of the me pharmacy. The Administrator was considered with the DON who is call the physician who beerved with seizu physician when any not available.  The Administrator was jeopardy on 12/20/2  The facility provided jeopardy removal plants of the nonconsidered with seizu physician when any not available.	agency staff failed to notify edication was not available. Idicated if medication did not call the pharmacy to find out dication or call their back up ninistrator indicated he did not cation would run out or why no rmacy for the Vimpat.  Inducted on 12/20/23 4:33 pm ndicated staff should always hen any resident was re activity and notify the residents medications were  as notified of immediate as at 1:40 PM.  If the following immediate an:  ipients who have suffered, or a serious adverse outcome as	F 7	755		
	the following approx 12/4/23 at 2:30 PM, at 10:10 AM, and 12 resident's Vimpat was facility and the nurse remove medication system.	ncidents of seizure activity on timate dates and times 12/5/23 at 8:18 AM, 12/5/23 2/5/23 at 1:47 PM. The as not available within the es did not have access to from the emergency supply ated when he was first notified				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345356	B. WING		C 12/28/2023
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP CODE  300 NORTH MAIN STREET  RICH SQUARE, NC 27869	12/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 755	resident and wanted He indicated there we the resident, so he s " Resident #3's Wand received from p	y on 12/5/23 he assessed the A Ativan to be administered. was no Ativan accessible for sent the resident to the ER.  Gimpat was ordered on 12/4/23 harmacy 12/6/23. All other	F 75	5	
	12/4/23 by the DON " All other resider reviewed on 12/21/2 were available. Any medication with less	onfirmed to be available on . ints' medication orders were 23 to ensure all medications residents who had a than a week's supply lered. This action was			
	the process or syster adverse outcome from the action will " All licensed nur were educated by the medication from the system per facility possible 12/21/23 no nurse word medication cart prioos The Administrator, I will ensure compliar "Newly hired lice agency staff, will be medications from the system per facility possible paccordingly in orient Director beginning 1 Resources Director the Administrator. "The nurse or missing adversarial states of the system per facility possible paccordingly in orient Director beginning 1 Resources Director the Administrator."	ses, including agency staff, ne DON on accessing emergency dispensing olicy and procedure on will be permitted to work the r to completing education.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		345356	B. WING			1	28/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
DIOLI COL	LARE NUROINO A RELIA	<b>n</b>		3	00 NORTH MAIN STREET		
RICH SQL	JARE NURSING & REHA	.B		F	RICH SQUARE, NC 27869		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 755	Continued From page	÷ 52	F	755			
	12/21/23 from the DO	N and pharmacy consultant					
	on reordering medica	tions observed to have less					
	than a week supply a	vailable via the EMAR					
	system.						
		ed charge nurse access from					
		emergency medication The charge nurse access					
	allows the DON to gra						
	working at the facility.						
		ely granting access to the					
	nurses for the emergency medication system.						
		lable as needed to obtain					
		ns until there is at least one					
		ccess to the emergency					
	medication system.	ting Officer conducted a					
	conference call on 12	•					
		emergency medication					
	availability and acces						
	director. The pharma						
	emergency medicatio	n supply system is available					
		ment medications are					
		through the inventory					
	control system when						
		service day after being binet. New and refill orders					
		urs of receiving order unless					
	order is written for sta	_					
		ovide additional monthly					
		peginning 12/21/23 for the					
	nurses and medicatio						
		ation, ordering, accessing					
	emergency supply an available.	d all other services					
	Alleged date of imme 12/22/23	diate jeopardy removal:					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
		345356	B. WING _		1	C <b>2/28/2023</b>
	ROVIDER OR SUPPLIER  JARE NURSING & REH	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	, <u> </u>	2/20/2020
(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 CORRECT ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 755	Continued From pag		F 7	755		
F 760 SS=K	removal plan was co audit of medication of completed and any removes week's supply were and interviews confir completed as indicate accessing medication dispensing system perocedure and reord to have less than a very DON received access emergency medication process of granting at the DON was available emergency medication one nurse per shift we medication system. conference call with to be completed. The is responsible for ene educated in orientatif from the emergency facility policy and protection that the pharmacy is to perin-service education medication aides regardinistration, order supply and all other simmediate jeopardy was verified. Residents are Free of CFR(s): 483.45(f)(2) Residents are sidents are sidents.	ed. The education included: In from the emergency er facility policy and ering medications observed week supply available. The s from the pharmacy to the on system, was in the access to facility nurses and ole as needed to obtain ons until there was at least with access to the emergency The Chief Operating Officer the pharmacy was confirmed the HR Director confirmed she suring all new staff are on on accessing medications dispensing system per ocedure. It was verified that rovide additional monthly for the nurses and tharding medication ing, accessing emergency services available. The removal date of 12/22/23 of Significant Med Errors	F7	760		1/26/24
	medication errors. This REQUIREMEN	Γ is not met as evidenced				

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345356	B. WING		C 12/28/2023		
NAME OF P	ROVIDER OR SUPPLIER	1 1111		STREET ADDRESS, CITY, STATE, ZIP CODE		12/20/2023	
				300 NORTH MAIN STREET	_		
RICH SQ	UARE NURSING & REHA	AB					
	T			RICH SQUARE, NC 27869			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 760	Continued From page	e 54	F 76	0			
	by: Based on record rev Emergency Medical S pharmacist, and phys failed to administer a to a resident for a per consecutive days and 12/5/23). Resident # seizure activity betwee EMS was contacted of was transported to the where Vimpat was ach had no further seizure Vimpat in the ER and facility the same day, the resident was not the anticonvulsant on missed doses. This of (Resident #3) whose  Immediate Jeopardy the facility failed to ac antiseizure medicatio was removed on 12/2 provided an acceptate immediate jeopardy re-	iew and interviews with staff, Services (EMS) personnel, sician interviews, the facility n anticonvulsant medication		F 760  1. How corrective action will accomplished for resident(s) for have been affected. Resident # 3 was sent to the E 12/05/23 and received his med Vimpat. The medication was reand received at the facility on other medication orders were and medications were available 12/04/23 by the Director of Nu 2. Identify other residents we potential to be affected All other residents' medication were reviewed on 12/21/23 to medications were available an administered as ordered. Any who had a medication with less week's supply available were a This action was completed by and MDS nurse.  3. What measures will be put to ensure the identified issue of occur in the future? All full-time, part-time, prn, and licensed nurses and medication.	ereordered orders ensure all ad being residents st than a reordered. the DON ut in place does not dication eordered 12/06/23. All reviewed, le on ursing. vho have the		
	with potential for mor not immediate jeopar	a pattern of no actual harm e than minimal harm that is dy) to ensure completion of		were educated by the DON or medication errors included mis medications, the significant ris residents and the consequence	ssed sks to		
	place are effective.	onitoring systems put into		notifying the physician and DC medications not administered	ON of		
	The findings included			instructions can be given to re risk to residents' health per fac	cility policy		
	and readmitted to the diagnoses which incli	nitted to the facility on 3/2/23 facility on 11/13/23 with uded traumatic subdural disorder/epilepsy, traumatic		and procedure beginning 12/2 licensed nurse or medication a work until education has been Nurses are to contact the DON	aide will completed.		

i '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII				С	
		345356	B. WING			12/28/2023		
NAME OF P	ROVIDER OR SUPPLIER	I		STREE	T ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	12/20/2020	
				300 NC	ORTH MAIN STREET			
RICH SQ	UARE NURSING & RE	HAB		RICH	SQUARE, NC 27869			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI	ION	(X5)	
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE	
F 760	Continued From pa	age 55	F 7	760				
	brain injury, gastro	stomy status (a tube surgically		ph	nysician via phone immediately wh	nen		
	placed into the stor				sident medication errors occur or			
				an	ticipated to occur for further			
	_	ificant change Minimum Data		I .	structions.			
		identified the resident as		- 1	I newly hired and agency staff (lic			
	having moderately impaired cognition. The MDS				urses and medication aides) will be			
	coded the resident as having seizure				ducated on preventing medication	errors		
	disorder/epilepsy and for gastrostomy (G-tube) status.				cluding missed medications, the gnificant risks to residents and the			
	Status.			,	onsequences for not notifying the	5		
	Resident #3's phys	sician orders for November		- 1	nysician of medications not admini	istered		
		order initiated on 10/15/23 for			further instructions can be given			
		n 10/milligrams (mg)/milliliters		l l	duce the risk to residents' health p			
		a G-tube two times a day for		- 1	cility policy and procedure, accord	•		
	seizures. Give 250	mg/25ml two times a day.		in	orientation prior to working the flo	oor.		
				Th	ne DON and Human resources wil	II		
		dated 9/25/23 revealed an		- 1	sure education is complete prior t			
		acid oral solution give 10 ml via		- 1	lowing staff to work the medication			
	G-tube three times	a day related to epilepsy.		- 1	4. Indicate how the facility plans to			
	Resident #3's Nove	ember 2023 electronic		- 1	onitor its performance to make su e deficient practice does not reocc			
		stration Record EMAR		- 1	ne Director of Nursing/designee w			
		ent's last dose of Vimpat was			pserve med pass three times a we			
		/24/23 at 8:00 pm. The EMAR		- 1	relve weeks.			
		no doses of Vimpat were		Th	ne Director of Nursing/Designee w	vill		
		esident #3 from 11/25/23			ıdit 5 residents meds daily for ava		,	
	through 11/30/23.			5 (	days a week for 12 weeks.			
				Th	ne Administrator will discuss the a	udit		
		ember EMAR documented no			sults with the IDT during the mont	thly		
		ere administered to Resident			uality Assurance Performance			
		hrough 12/06/23 with the first			provement meeting for three mor			
		during 3rd shift on 12/06/23 at		I .	ne audits will be reviewed to ensur			
	8:00 pm.			- 1	ompliance is ongoing and will dete			
	The Medication Ad	ministration Record (MAR) and			nether there is a need for further a -education, or modification.	auuilS,		
		ealed the following information		16.	-caacation, or mounication.			
	for Resident #3:	calca the following information						
		AR indicated no doses of						
		nistered and a nurse's note						

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		345356	B. WING _			C 12/28/2023
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH MAIN STREET RICH SQUARE, NC 27869	E	12/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	order 11/26/23: The MAR Vimpat were adminis written by Nurse #6 I order 11/27/23: The MAR Vimpat were adminis	revealed Vimpat was on indicated no doses of stered and a nurse's note revealed Vimpat was on indicated no doses of stered and a nurse's note	F 7	760		
	stock and a prescript provider 11/28/23: The MAR Vimpat were adminis written by Nurse #2 spharmacy." - 11/29/23: The MAR Vimpat were adminis written by Nurse #2 spharmacy." - 11/30/23: The MAR Vimpat were adminis written by Nurse #8 r not available.	indicated no doses of stered and a nurse's note stated, "Coming from indicated no doses of stered and a nurse's note evealed the medication was				
	were administered an Nurse #3 indicated the available 12/2/23: The MAR were administered an Nurse #5 indicated the available 12/3/23: The MAR were administered an Nurse #5 indicated the available 12/4/23: The MAR were administered an Nurse #2 stated, "Or	indicated no doses of Vimpat and a nurse's note written by the medication was not sindicated no doses of Vimpat and a nurse's note written by the medication was not sindicated no doses of Vimpat and a nurse's note written by the medication was not sindicated no doses of Vimpat and a nurse's note written by the medicated no doses of Vimpat and a nurse's note written by the order."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345356	B. WING		12/28/2023	
	ROVIDER OR SUPPLIER  JARE NURSING & REH	АВ		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	,	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
F 760	note written by Nursing Director of Nursing An interview was co am with staff Nurse Resident #3 his last 11/24/23. She stated physician as the har to the physician before A telephone intervie at 4:47 pm with age Resident #3 ran out 11/25/23, she called request a reorder or revealed 11/26/23 wand she was not aw not available.  A nurse's note writte 12/04/23 at 2:30 pm was seen this mornistaff during this shiff she arrived at his roshowing seizure act questions like he wo stated Nurse #2 and resident was comple normal. Resident #3 no further seizure act and seizure act act and seizure act act and seizure act and seizure act act act and seizure act act act act act and seizure act	dministered and a nurse's e #1 stated, "Out of stock. and provider notified."  Inducted on 12/20/23 at 10:12 #4 who stated she gave dose of Vimpat on 3rd shift d she did not call the d prescription had been faxed one the medication ran out.  W was conducted on 12/20/23 may have he stated that of his prescription on and faxed the physician to a Resident #3's Vimpat. She has the last day she worked, hare Resident #3's Vimpat was he having seizure activity by hurse #2 indicated when om the resident was not invity but wasn't answering hald normally do. The note of the stated that responding like the was in stable condition and civity was observed.	F 76	,		
	pm with agency Nur administered the me 11/29/23, and 12/4/2 was a controlled sub a signed prescription	nducted on 12/19/23 at 2:30 se #2 who had not edication on 11/28/23, 23. Nurse #2 indicated Vimpat ostance, and they would need in to reorder. She stated when not available, she called the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345356	B. WING _			C <b>12/28/2023</b>
	ROVIDER OR SUPPLIER  JARE NURSING & REH	АВ		STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH MAIN STREET RICH SQUARE, NC 27869	DDE	12/10/1010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 760	coming on 11/29/23 called the pharmacy medication was on it stated when the seiz arrived on 12/04/23 she notified the currand gave her a presphysician.  A nurse's note writte 10:14 am revealed riggs or symptoms of discomfort. Alert to plathed and shaved 8:18 am. Resident diapproximately 2 min again at 10:10 am w DON notified. Will not contact.  An interview was con AM with the facility's position on 11/27/23 first made aware on Resident #3's Vimparadministration and contact was not called the pharmacy told it was found bag	sold the medication was She indicated when she 11/29/23, she was told the Its way. Agency Nurse #2 It we medication had not when she returned to work ent Director of Nursing (DON) cription to fax to the  In by Nurse #1 on 12/05/23 at esident resting in bed no of pain, distress, or person. Rehabilitation Aide #3 resident at approximately isplayed seizure like activity utes or less in duration. And while working with therapy. Outlify provider and family  Inducted on 12/20/23 at 10:16 In current DON who took the In the DON reported she was 12/04/23 by Nurse #2 that at had not been available for alled the pharmacy that day. In armacy told her the	F	760		
	received his first dos the evening. The DO had not gone to the #3's Vimpat. The DO	ing day and the resident se as ordered on 12/06/23 in ON could not explain why staff pharmacy to pick up Resident ON indicated Resident #3's aled prior to the evening dose				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345356 B. WING				C  2/28/2023	
	ROVIDER OR SUPPLIER  JARE NURSING & REHA			STREET ADDRESS, CITY, STATE, ZIP COI 300 NORTH MAIN STREET RICH SQUARE, NC 27869	•	2/20/2023	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 760	Continued From pag	e 59	F 7	60			
		ed at the facility on 12/06/23, the medication at the facility					
	pm with the Administ of the issue with the vimpat they were in the pharmacy, the DON pharmacy, and were The Administrator reprotify the facility pharmacy and the prescription stated he was not awhis medication, most agencies and these amanagement the me The Administrator incarrive, staff should cathe status of the medication why the medication which who why the medication which will be the pharmacy. The Administrator incarrive, staff should cathe status of the medication which who why the medication which who what the pharmacy. The Administrator incarrive, staff should cathe status of the medication which who what the medication which is the pharmacy. The Medical Director 12/19/23 at 1:58 PM he could not recall the by staff that Resident stated he could not conceive the stated he c	was new, and staff called the told the Vimpat was coming. Corted that nurses should remacist when they were out stify the physician so he could in a timely manner. He ware Resident #3 was out of of the staff were from agency staff failed to notify dication was not available. Sticated if medication did not all the pharmacy to find out lication or call their back up nistrator indicated he did not ation would run out or why no macy for the Vimpat.  The was interviewed on and 2:16 PM. He indicated e exact date, but he was told to the training that the training that the was told to the training that th					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345356	B. WING		12/28/2023	
	ROVIDER OR SUPPLIER  UARE NURSING & REH	НАВ	3	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH MAIN STREET RICH SQUARE, NC 27869	12/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 760	nurse informed EMS out to the hospital p the facility not havin (Vimpat). When ask seizures the nurse i seizures on this dat 8:18 am, 10:10 am the facility at 3:25 p at 3:56 pm. No seiz transport. While givinurse, Resident #3 seizure.  A telephone intervie at 12:48 pm with EM arrived to the reside available to give repnursing staff to give reported that Reside the hospital per phy facility not having th (Vimpat). EMS #1 s Resident #3 went 4 and she could not a have his Vimpat.  The hospital record Resident #3 presen history of seizures, date and had been (11/24/23). He was responsive but confindicated he was tre IV (intravenous), an was noted. The record facility, reports med up from the pharma	ge 60 If to give them a report. The Single Resident #3 was being sent er physician request due to gethe resident's medication and about the resident having indicated Resident #3 had 3 are (12/5/23) at these times: and 1:47 pm. EMS departed in and arrived at the hospital fure activity was noted during fing a report to the hospital was noted to start having a set where were no staff foort and he had to request them a report. EMS #1 and he had to request them a report. EMS #1 are #3 was being sent out to sician request due to the fine resident's medication stated he asked the nurse why answer, just said they did not dated 12/05/23 revealed ted on 12/05/23 for prior had three seizures on this out of Vimpat since Friday noted as alert, verbally used. The hospital report and the resizure activity for did the sizure activity for did not been picked by medications as	F 760			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	DATE SURVEY COMPLETED
		345356	B. WING			C
	ROVIDER OR SUPPLIER  JARE NURSING & REH			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	ı	12/28/2023
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 760	A phone interview w 1:20 pm with the faci indicated Resident # Vimpat ran out on 1 was sent to the ER Pharmacist #1 state Vimpat for 10 days I potential for seizure attempted delivery t and could not delive attempt to deliver th facility and returned  The Administrator w jeopardy on 12/20/2  The facility provided jeopardy removal plane  1. Identify those re or are likely to suffer as a result of the no Resident #3 was ide the noncompliance. The facility failed to medication (Vimpat) Resident #3 from 11 resulting in 19 misse Resident #3 experient 12/4/23 and again of transferred to the ho Vimpat in the ER on seizure activity was he did not receive him	dent #3's diagnoses were and seizure disorder.  as conducted on 12/28/23 at a conducted on 12/28/23 at a conducted on 12/28/23 at a conducted on 12/05/23 at a conducted on 12/05/23 at a conducted the 1/25/23 and on 12/05/23 here for seizure activity. In the different of the different activity of that abruptly stopping the Resident #3 would have the second the conducter of the Vimpat, the second and the Vimpat to the pharmacy.  as notified of immediate and at 1:40 PM.  The following immediate and a serious adverse outcome ancompliance;  antified as being affected by a conducted and seconducted and a serious adverse outcome ancompliance;	F 76	50		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345356	B. WING				28/2023
	ROVIDER OR SUPPLIER  JARE NURSING & REHA	AB	1	3	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NORTH MAIN STREET RICH SQUARE, NC 27869		-0.2020
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	and received on 12/6 orders were reviewed available on 12/04/23  All other residents' m reviewed on 12/21/23 were available and bordered. Any residentless than a week's sureordered. This action DON and MDS nurses  2. Specify the action the process or system adverse outcome from when the action will but a licensed nurses and educated by the DON errors included misses significant risks to resconsequences for no DON of medications instructions can be giresidents' health per beginning 12/21/23. medication aide will where completed. Nur and physician via phoresident medication experience.	t was reordered on 12/4/23 i/23. All other medication d, and medications were by the DON.  dication orders were to ensure all medications eing administered as ts who had a medication with apply available were m was completed by the e.  In the entity will take to alter m failure to prevent a serious m occurring or recurring, and the complete.  In the entity will take to alter m failure to prevent a serious m occurring or recurring, and the complete.  In the entity will take to alter m failure to prevent a serious m occurring or recurring, and the complete.  In the entity will take to alter m failure to prevent a serious m occurring or recurring, and the complete.  In the entity will take to alter m failure to prevent a serious m occurring or recurring, and the complete.  In the entity will take to alter m failure to prevent a serious m occurring or recurring, and the complete.  In the entity will take to alter m failure to prevent a serious m occurring or recurring, and the complete.  In the entity will take to alter m failure to prevent a serious m occurring or recurring, and the complete.  In the entity will take to alter m failure to prevent a serious m occurring or recurring, and the complete of the entity will take to alter m failure to prevent a serious m occurring or recurring, and the complete of the entity will take to alter m failure to prevent a serious m occurring or recurring, and the complete of the entity will take to alter m failure to prevent a serious m occurring or recurring.	F	760			
	nurses and medication	nd agency staff (licensed on aides) will be educated on n errors including missed					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
		345356	B. WING			C <b>12/28/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	I	12/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 760	the consequences of medications not instructions can be residents' health per accordingly in orier floor. The DON and education is completed work the medication. The regional nurse with the DON and educations.  Alleged date of immark the period of the regional nurse with the DON and educations.  Alleged date of immark the period of the regional nurse with the reordered. Inservice confirmed educated and covered preventional plan was a medication with le reordered. Inservice confirmed educated and covered preventional nurse designed the residents and the notifying the physical not administered so given to reduce the facility policy and phuman Resources is now included in corresponsible for ensecompleted prior to a and Administrator a meetings with the roversight and monitorial properties.	gnificant risks to residents and for not notifying the physician administered so further given to reduce the risk to er facility policy and procedure, station prior to working the Human resources will ensure ete prior to allowing staff to	F7	60		

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED	
	345356	B. WING		C <b>12/28/2023</b>	
ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 IZIZOIZOZO	
			300 NORTH MAIN STREET		
UARE NURSING & REH	АВ		RICH SQUARE, NC 27869		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
A facility must be addingled in the control of the areas of physician of change in condition residents, competent emergency medication of change in condition residents, competent emergency medication and administration. The condition receive his seizure experienced seizure	ministered in a manner that esources effectively and maintain the highest mental, and psychosocial sident.  I is not met as evidenced on, record review, interviews dialysis center nurse, and Services staff, pharmacist cility failed to provide and oversight to ensure ses were in place as ous deficient practices in roupings resulting in and substandard quality of verity deficiencies were in notification, management in, safe transportation of a nursing staff, routine and on availability, accessibility Residents #1 and #2 were evan safely using transport seat belts. Resident #3 did re medication as ordered and activity. These incidents had	F 83	F 835  1. How corrective action will be accomplished for resident(s) found to have been affected. Residents #1, #2, and #3 were identifias affected by the deficient practice. 2. All residents have the potential traffected. 3. On 12/21/23 The Chief Operation Officer reviewed policies and educate the Administrator on oversight of facilit transportation including educating and monitoring drivers, safety procedures following manufacturers recommendate for transporting residents. On 12/21/23 The Chief Operations Office reviewed policies and educated the Administrator and Director of Nursing (DON) on oversight of nursing staff	o be  ns d ty d and tion	
of 46 residents resid high likelihood of affe Immediate jeopardy lack of leadership an safe transportation o resident falling out of	ing in the facility and had a ecting other facility residents.  began on 11/1/23 when a d oversight in the area of f Resident #1 resulted in the the chair during transport.		emergency medications, identifying resident's emergency needs, reporting events through chain of command, ar notifying physicians.  On 12/21/23 The Chief Director of Operations reviewed policies and educated the Administrator on the	g id	
	ROVIDER OR SUPPLIER  SUMMARY ST (EACH DEFICIENC REGULATORY OR  Administration CFR(s): 483.70  §483.70 Administrati A facility must be adr enables it to use its r efficiently to attain or practicable physical, well-being of each re This REQUIREMENT by: Based on observation with residents, staff, Emergency Medical stand physician, the fa effective leadership as systems and process evidenced by numer multiple regulatory gr immediate jeopardy a care. These high se the areas of physicia of change in condition residents, competent emergency medication and administration. In not transported in the chairs and fastening not receive his seizur experienced seizure the high likelihood of death. These deficie of 46 residents residi high likelihood of affet  Immediate jeopardy lack of leadership an safe transportation or resident falling out of	Administration CFR(s): 483.70  §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	ROVIDER OR SUPPLIER  JAMER NURSING & REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Administration  CFR(s): 483.70  \$483.70 Administration.  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review, interviews with residents, staff, dialysis center nurse, and Emergency Medical Services staff, pharmacist and physician, the facility failed to provide effective leadership and oversight to ensure systems and processes were in place as evidenced by numerous deficient practices in multiple regulatory groupings resulting in immediate jeopardy and substandard quality of care. These high severity deficiencies were in the areas of physician notification, management of change in condition, safe transportation of residents, competent nursing staff, routine and emergency medication availability, accessibility and administration. Residents #1 and #2 were not transported in the van safely using transport chairs and fastening seat belts. Resident #3 did not receive his seizure medication as ordered and experienced seizure activity. These incidents had the high likelihood of serious harm, injury, or death. These deficient practices affected three of 46 residents residing in the facility residents.  Immediate jeopardy began on 11/1/23 when a lack of leadership and oversight in the area of safe transportation of Resident #1 resulted in the resident falling out of the chair during transport.	ROWIDER OR SUPPLIER  345356  BUNDARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY)  Administration  CFR(s): 483.70  \$483.70 Administration.  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:  Based on observation, record review, interviews with residents, staff, dialysis center nurse, and Emergency Medical Services staff, pharmacist and physician, the facility failed to provide effective leadership and oversight to ensure systems and processes were in place as evidenced by numerous deficient practices in multiple regulatory groupings resulting in immediate jeopardy and substandard quality of care. These high severity deficiencies were in the areas of physicain notification, management of change in condition, safe transportation of residents, competent nursing staff, routine and emergency medication availability, accessibility and administration. Residents #1 and #2 were not transported in the van safely using transport chairs and fastening seat belts. Resident #3 did not receive his seizure medication as ordered and experienced seizure activity. These incidents had the high likelihood of serious harm, injury, or eath. These deficient practices affected three of 46 residents residing in the facility and had a high likelihood of affecting other facility residents.  Immediate jeopardy began on 11/1/23 when a lack of leadership and oversight in the area of safe transportation of Resident #1 resulted in the resident falling out of the chair during transport.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	A. BUILDING			`
		345356	B. WING				28/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	12.	LUIZUZU
				3(	00 NORTH MAIN STREET		
RICH SQI	JARE NURSING & REHA	AB		R	RICH SQUARE, NC 27869		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 835	Continued From page	e 65	F	835			
	12/23/23 when the fa	cility provided an acceptable			included the expectations of oversight	and	
	credible allegation of				completion of all education and staff		
	removal. The facility r	remains out of compliance at			monitoring. This education also include	s	
	a lower scope and se	verity of E (no actual harm			the Administrator's responsibility to		
	with potential for more	e than minimal harm that is			maintain safe transportation and provid	е	
	not immediate jeopar	dy) to ensure education and			quality care based on the facility's qual	ty	
	monitoring systems p	ut into place are effective.			of care policy and daily monitoring to		
					ensure adherence to required supervis		
	The findings included	:			On 12/21/23 The Chief Operations Offi	cer	
					reviewed policies and educated the		
	This tag is cross-refe	renced to:			Administrator and DON regarding		
	\				reviewing the 24- hour report daily and		
	,	record review and interviews			discussing issues that need addressed		
		an, the facility failed to notify			through proper morning meeting	of	
		dical emergency when zure activity. Resident #3			communication. Ensuring all members the facility administration team are	OI	
		seizure activity between			following through with their job duties in	,	
	12/4/23 and 12/5/23.				reference to resident care and safety.	'	
		contacted and the resident			4. Indicate how the facility plans to		
	, ,	e Emergency Room (ER)			monitor its performance to make sure t	hat	
	-	eizure medication) was			the deficient practice does not reoccur.		
		sident had no further seizure			The Chief Operations Officer/Regional		
	activity after receiving	Vimpat and was			Nurse will conduct daily calls as well as	;	
		e facility the same day. This			weekly on-site meetings with the facility	,	
	occurred for 1 of 3 res	sidents (Resident #3)			Administrator and DON to ensure		
	reviewed for notificati	on of change.			compliance with all practice standards		
					discussed and that plan of correction is		
		record review and interviews			being followed.		
		Medical Services (EMS)			The Administrator will discuss the audit		
		t, and physician, the facility			results with the IDT during the monthly		
	failed to identify the s				Quality Assurance Performance		
		d the need for medical			Improvement meeting for three months	•	
	intervention for a resi	•			The audits will be reviewed to ensure		
		been provided with his on (Vimpat) since 11/25/23.			compliance is ongoing and will determi whether there is a need for further audi		
		incidents of seizure activity			re-education, or modification.	io,	
		12/5/23. Following the			To-caucation, or mounication.		
		3) the physician ordered					
	,	medication commonly used					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	, ,	DATE SURVEY COMPLETED
		345356	B. WING _			C 12/28/2023
	ROVIDER OR SUPPLIER  JARE NURSING & REH	AB		STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH MAIN STREET RICH SQUARE, NC 27869	ODE	12.20.2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ( X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 835	were unable to acce medication supply to facility. Emergency on the Emergency of the Emergency of the Emergency of experienced a fifth semergency room (El was administered in no further seizure accordance with for 1 of 2 residents of Emergency Medical of the Emergency Me	ion for seizures) via spection and the facility staff as the emergency Ativan to treat the resident in the Medical Services (EMS) was esident was transported to m (ER) and Resident #3 eizure upon arrival in the R). Intravenous (IV) Vimpat the ER and the resident had stivity and was discharged e same day. This occurred whose condition required Services.  In observation, record review, ents, staff, dialysis center by Medical Services staff, the de safe transportation in the desire transportation for 2 and for accidents (Resident on 11/1/23 Transportation a geriatric wheelchair (a wheels) to transport Resident #1 11/27/23 Transportation buckle Resident #2's seatbelt ation the resident fell out of the tonto the floor of the van. depain in her right shoulder dese incidents had the high harm, injury or death.	F	335		
	and interviews with r	n observation, record reviews residents, staff, dialysis center cy Medical Services staff, the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG	, ,	DATE SURVEY COMPLETED
		345356	B. WING _			C 12/28/2023
	ROVIDER OR SUPPLIER  JARE NURSING & REH	IAB		STREET ADDRESS, CITY, STATE, ZIP 300 NORTH MAIN STREET RICH SQUARE, NC 27869	CODE	12/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 835	#1, who was also a trained by staff who transportation van's for safe securement provided her with tranot aware that trans geriatric chair (a pace based) was not in a transportation van's In addition, the facilitariansportation Assistensure resident safe of 1 staff who transportation van. (Assistant #1 utilized chair) to transport R transportation the reconto the floor of the injured. On 11/27/2 did not buckle Resider transportation the reconto the floor of the injured. On 11/27/2 did not buckle Resider and onto #2 reported pain in I following day. This of likelihood of resultin death to residents we facility's transportation.  e) F755: Based or with staff, pharmacisfailed to obtain an a resident with a histor missed doses of the capable of accessin supply to treat a me was ordered Vimpat and from 11/25/23 till.	are Transportation Assistant facility Nurse Aide, was was aware of the facility's manufacturer's instructions when Nurse Aide #1 aining. Aide #1 aining. Nurse Aide #1 aining. Aide #1 aining. Nurse Aide #1 aining. Aid	F	835		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG	. ,	(X3) DATE SURVEY COMPLETED	
		345356	B. WING			C <b>2/28/2023</b>	
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIF 300 NORTH MAIN STREET RICH SQUARE, NC 27869		2/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 835	four incidents of sei and 12/5/23. Follow (12/5/23) the physic antianxiety medication for (IM) injection and the access the emerger was contacted and to the Emergency Fadministered. The reactivity after receiving discharged back to Upon return from the administered Vimpation 12/6/23 as the mediobtained from the practice was for 1 or pharmaceutical services was for 1 or pharmaceu	harmacy. Resident #3 had zure activity between 12/4/23 ring the fourth seizure sian ordered Ativan (an ion commonly used as a for seizures) via intramuscular refacility staff were unable to recy medication supply. EMS the resident was transported from (ER) where Vimpat was resident had no further seizure refacility the same day. The facility the same day. The facility the same day. This deficient for the resident reviewed for vices.  The record review and interviews refacility the seident for a period of 10 and resident #3 had four incidents retween 12/4/23 and 12/5/23. The facility of the Emergency Room (ER) return to the facility the redictional dose of the 2/6/23 for a total of 22 missed do for 1 of 1 resident (Resident).	F	835			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE COMF	SURVEY
		345356	B. WING		1	C <b>28/2023</b>
	ROVIDER OR SUPPLIER  JARE NURSING & REHA	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	, . <u>=</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 835	pm with the Administrative reported that nurses a pharmacist when the notify the physician substated he was unaward to be used in facility the stated the Maintenan Transportation Aide at the issue with the available view of the issue with the pharmacy and the Dinnew. He stated most agencies and these amanagement the medical management the medical view of the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with a An interview was confused on the indicated they had communication with	ducted on 12/20/23 at 12:55 rator. The Administrator should notify the facility by were out of medication and to he could sign the ly manner. The Administrator re that geri chairs were not ransportation vans. He ce Director did not train ref. He stated at the time of failability of Resident #3's ransition with a new rector of Nursing (DON) was of the staff were from regency staff failed to notify dication was not available. In inconsistent regency nurses.  ducted with the Chief refoo) on 12/28/23 at 1:00 was working with the reforming the control of the staff were delivered reference. The COO stated she repharmacy to correct the medications were delivered  s notified of immediate at 1:40 PM. The following immediate of the with a removal date of	F 83			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
		345356	B. WING			C <b>12/28/2023</b>
	ROVIDER OR SUPPLIER  JARE NURSING & REH			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	·	12/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 835	and oversight to ensprocesses were in processes and emergency media accessible, and admensure safe transpoor Residents #1 and #2 while being transport to slide from their cheff of the physician or see resident when he has resident when he has residents #1, #2, and affected by the deficient practice. Specify the action the process or system for adverse outcome frowhen the action will On 12/21/23 The Chreviewed policies and on oversight of facility educating and monitiprocedures, and followed policies and Director of Nursing staff administ pharmacy processes accessing emergences.	provide effective leadership sure effective systems and lace to manage change in notification, to ensure routine dications were available, ninistered as ordered, and relation of residents.  Were not properly secured ted in the van causing them lairs onto the floor. Resident is seizure medication as failed to immediately notify it is were activity.  In #3 were identified as lient practice.  We potential to be affected by expected to prevent a serious of occurring or recurring, and be complete. The properties of the educated the Administrator that the educated the educated the educated the educated the educated the edu	F8	35		

C <b>12/28/2023</b>
12/20/2023
(X5) COMPLETION DATE

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25.			(	c	
		345356	B. WING			12/	28/2023	
	ROVIDER OR SUPPLIER  JARE NURSING & REHA			30	TREET ADDRESS, CITY, STATE, ZIP CODE  NO NORTH MAIN STREET  ICH SQUARE, NC 27869			
(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 835 F 867 SS=E	to reduce the risk to repolicy and procedure conducted of Transposecuring a resident in van according to mar recommendations. Twere participating in valls with the Chief O oversight and monitor correction is being fol jeopardy removal dat QAPI/QAA Improvem CFR(s): 483.75(c)(d)(d)	er instructions can be given esidents' health per facility. An observation was ortation Assistant #2 the facility's transportation aufacturer's he DON and Administrator weekly meetings and daily perations Office for general ring to ensure the plan of lowed. The immediate e of 12/23/23 was verified. ent Activities (e)(g)(2)(i)(ii)		835			1/26/24	
	monitoring. A facility must establish policies and procedure collections systems, and adverse event monitor procedures must include following:  §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representative information will be used are high risk, high volop opportunities for impression from all direct to the facility systems to identify, conformation from all direct to the facility systems to the facility systems to the facility to the facility must be stable and procedure.	and monitoring, including wing. The policies and ude, at a minimum, the maintenance of effective d use of feedback and input other staff, residents, and wes, including how such ed to identify problems that ume, or problem-prone, and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345356	B. WING		C 12/28/2023		
	ROVIDER OR SUPPLIER  UARE NURSING & REH	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE  300 NORTH MAIN STREET  RICH SQUARE, NC 27869	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 867	indicators.  §483.75(c)(3) Facilitiand evaluation of perincluding the methodevelopment, monitively facilitian including the method systematically identianalyze and use data diverse events in the facility will use the diprevent adverse events in the facility will use the diprevent adverse events in the facility will use the diprevent adverse events in the facility will use the diprevent adverse events in the facility will use the diprevent adverse events in the facility will use the diprevent adverse events in the facility will be designed to events are results.  §483.75(d)(1) The facility in the facility will be designed to events are results.  §483.75(d)(2) The facility will be designed to events affectly problems; and (iii) How the facility of its performance in the facilit	lop and monitor performance  ty development, monitoring, erformance indicators, dology and frequency for such oring, and evaluation.  ty adverse event monitoring, ds by which the facility will ify, report, track, investigate, ta and information relating to the facility, including how the ata to develop activities to tents.  In systematic analysis and  acility must take actions the improvement and, after actions, measure its success, the endized and sustained.  acility will develop and addressing: the a systematic approach to g causes of problems thems; welop corrective actions that effect change at the systems lity of care, quality of life, or	F 86	7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345356	B. WING _		,	C 12/28/2023	
	ROVIDER OR SUPPLIER  JARE NURSING & REHA	AB		STREET ADDRESS, CITY, STATE, ZIP CC 300 NORTH MAIN STREET RICH SQUARE, NC 27869		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 867	performance improve high-risk, high-volume consider the incidence of problems in those outcomes, resident siresident choice, and siresident choice, and siresident events, analy implement preventive that include feedback facility.  §483.75(e)(3) As partimprovement activitied distinct performance number and frequence conducted by the faciand complexity of the available resources, assessment required Improvement projects annually a project that problem-prone areas collection and analys (c) and (d) of this section is \$483.75(g) Quality as \$483.75(g)(2) The quassurance committee governing body, or defunctioning as a governing body.	cility must set priorities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care.  mance improvement nedical errors and adverse yze their causes, and actions and mechanisms and learning throughout the experiment of improvement projects. The experiment projects and activity services and as reflected in the facility at §483.70(e). In must include at least at focuses on high risk or identified through the data are described in paragraphs tion.	F8	67			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345356	B. WING		C 12/28/2023	
	ROVIDER OR SUPPLIER  UARE NURSING & REH	АВ		STREET ADDRESS, CITY, STATE, ZIP CODE  300 NORTH MAIN STREET  RICH SQUARE, NC 27869	•	
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F 867	(e) of this section. The continued failure showed a pattern of sustain an effective sy The continued failure showed a pattern of sustain an effective sy This tag is cross reference. This tag is cross reference and physical section of the sustain and the	der paragraphs (a) through the committee must:  lement appropriate plans of ntified quality deficiencies; and analyze data, including the QAPI program and data regimen reviews, and act on ke improvements.  T is not met as evidenced view and staff interview the ressment and Assurance maintain implemented nitor interventions that the result in place following and complaint investigation the deficiency is in the area of reand leadership to ensure and restems and processes (F835). The during two federal surveys the facility's inability to Quality Assurance Program.	F 86	,	ras  , IPI tiffied ty es, he the ere or de	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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		345356	B. WING			12/	28/2023
NAME OF PROVIDER OR SUPPLIER  RICH SQUARE NURSING & REHAB		AB		30	TREET ADDRESS, CITY, STATE, ZIP CODE  OO NORTH MAIN STREET  ICH SQUARE, NC 27869		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	residents, competent emergency medication and administration. From transported in the chairs and fastening sometimes not receive his seizur experienced seizure at the high likelihood of death. These deficies of 46 residents residing high likelihood of affer the deficiency of the properties of the pr	n, safe transportation of nursing staff, routine and on availability, accessibility Residents #1 and #2 were a van safely using transport seat belts. Resident #3 did be medication as ordered and activity. These incidents had serious harm, injury, or ent practices affected three and in the facility and had a cting other facility residents.	F	867			
	leadership to ensure abuse and to prevent physical abuse from a An interview with the conducted on 12/28/2 the facility attempted issues that were iden further stated the faci administrative staff w to the repeat citation. facility in May 2023. been turnover in the I and the new Director He added the facility which may have also Administrator reporte Assessment and Assi monthly and they look	Administrator was 23 at 1:37 PM. He reported to correct any on-going tified. The Administrator lity had some turnover in hich may have contributed He reported he came to the He further stated there had Director of Nursing position of Nursing started 11/27/23. was utilizing agency staff led to repeat citation. The d that the facility's Quality urance committee met ked at trends to identify rated employees were					

CENTERS FO	OR MEDICARE & MEDICAID SERVICES			A FORM					
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY					
NO HARM WIT	TH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:					
FOR SNFs AND	) NFs	345356	B. WING	12/28/2023					
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDRESS, C	CITY, STATE, ZIP CODE						
RICH SQU	ARE NURSING & REHAB	300 NORTH MAI RICH SQUARE,	300 NORTH MAIN STREET RICH SQUARE, NC						
ID									
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE	ES							
F 842	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)							
	§483.20(f)(5) Resident-identifiable information.  (i) A facility may not release information that is resident-identifiable to the public.  (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.								
	§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	professional standard	s and practices, the facility must maintain						
	§483.70(i)(2) The facility must keep confider regardless of the form or storage method of (i) To the individual, or their resident repres (ii) Required by Law; (iii) For treatment, payment, or health care 164.506; (iv) For public health activities, reporting of judicial and administrative proceedings, law	f the records, except vesentative where permit operations, as permit of abuse, neglect, or dw enforcement purpos	when release is- itted by applicable law;  ted by and in compliance with 45 CFR  omestic violence, health oversight activitieses, organ donation purposes, research						
	purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.								
	§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.								
	§483.70(i)(4) Medical records must be reta (i) The period of time required by State lav (ii) Five years from the date of discharge w (iii) For a minor, 3 years after a resident re	v; or when there is no requir							
	§483.70(i)(5) The medical record must con (i) Sufficient information to identify the res (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and so (iv) The results of any preadmission screen	sident; ervices provided;	ew evaluations and determinations conduc	ıted					

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

The above isolated deficiencies pose no actual harm to the residents

Event ID: 48ST11 If continuation sheet 1 of 2

NIEKS FOR MEDICA			i	A FO
FATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY
PHARM WITH ONLY A POTENTIAL FOR MINIMAL HARM R SNFs AND NFs  ME OF PROVIDER OR SUPPLIER  CH SQUARE NURSING & REHAB			A. BUILDING:	COMPLETE:
		345356	B. WING	12/28/2023
		STREET ADDRESS, CITY, STATE, ZIP CODE  300 NORTH MAIN STREET RICH SQUARE, NC		
EFIX G	SUMMARY STATEMENT OF DEFICIEN	NCIES		
by the S (v) Phys (vi) Lab This RE Based of record to accident The find Resident A facility concern Review facility's During a transport someon wheeled seatbelt. An investment of Resident An interest of Resident Assistant	sician's, nurse's, and other licens poratory, radiology and other dia EQUIREMENT is not met as even record review and staff interview that included a fall in the facility's.  Signature of the facility of Resident #2's medical record a transportation van on 11/27/23.  The phone interview with Transporting Resident #2 and Resident #2 and Resident #2 and Resident #3 and record the pulled out in front of her and signature on the facility of the transportation of the van onto the floor	gnostic services reports a idenced by: ew, the facility failed to is transportation van for a on 11/20/23.  Lesident #2 dated 11/27/2 is transportation van. The did not reveal any evide tration Assistant #1 on 12/4 on 11/27/23 in the facility secure the resident was not part of the medical diministrator on 12/19/23 in the facility's transport in the facility is transport in the facility in the facility in the facility is transport in the facility in the facility in the facility is transport in the facility in the facility in the facility is transport in the facility in the facili		e